1150 Conn Ave.
Dr. M. Feeney

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216 — 11345

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: 9001 Old Georgetown Road

City or town: Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9001 Old Georgetown Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SISTER VINCENT AHERN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 12, 1860

8. AGE: Years	Months	Days	If less than one day
87			hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Thomas Ahern

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Jane Looney

15. Birthplace: Ireland

16. Informant: Sisters of Visitation

Address: 9001 Old Georgetown Road

17. (Burial, cremation, or removal. Which?): Burial — Date thereof: Dec 3, 1947 (month) (day) (year)

Cemetery or crematory: Sisters of Visitation Cemetery

Location: Bethesda Maryland

18. Funeral director: W. W. Chambers Co.

Address: 3072 M Street N.W.

19. 12/8/47 (Date rec'd by registrar) — Wm E Jobes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2, 1947, at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947, to Dec 2 1947

and that I last saw h.e alive on Dec 1 1947

Immediate cause of death	DURATION
Coronary arteriosclerotic	mo 1
Heart Disease	yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: No

Date of op.:

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Michael J. McInerney M.D.
M. D. or other

Address: 1150 Conn Ave. Date signed: 12-2-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11350

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 1 day

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1116 7th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: ANDERSON, Frank

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	married

6.(b) Name of husband or wife: Myrtle Anderson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15, 1888

8. AGE: Years	Months	Days	If less than one day
59	9	3	hrs. min.

9. Birthplace: La.
(Town, county, and state)

10. Usual occupation: Delivery Man

11. Industry or business:

FATHER
12. Name: ANDERSON, Lewis dec
13. Birthplace: La.

MOTHER
14. Maiden name: CURETON, Emmerline dec.
15. Birthplace: La.

16. Informant: wife: Mrs. Myrtle Anderson
Address: 1116 7th St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-23-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis

Address: 1432 U St., N.W., Wash., D.C.

19. 12-19 19 47 (Date rec'd by registrar) Mary C. Patterson registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 December 19 47 at 10:02 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 17 November 19 47 to 18 Dec. 19 47 and that I last saw him alive on 18 Dec. 19 47

Immediate cause of death	DURATION
Hypertensive Heart Disease	indef
with uremia	
Due to: Nephritis Chronic	
Due to: 1364	
Other conditions: Periurethral abscess;	indef

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Confirmed above

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. R. Cooper H. R. COOPER, Lt. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-19-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g+ S 11351

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one month, 7 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or Institution? 1 Mon, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 611 Florence St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWII

3.(a) FULL NAME: ATKINSON, William

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	married

6.(b) Name of husband or wife: Hannah R. Atkinson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 27, 1909

8. AGE: Years	Months	Days	If less than one day
37	11	11	hrs. min.

9. Birthplace: S.C. (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business

FATHER
12. Name: ATKINSON, Lemmel, dec.
13. Birthplace: S.C.

MOTHER
14. Maiden name: McDoul, Mary dec.
15. Birthplace: S.C.

16. Informant: wife: Mrs. Hannah R. Atkinson
Address: 611 Florence St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-11-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis B.J.
Address: 1432 U St., N.W., Wash., D.C.

19. 12-8-47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 Dec. 1947 at 6:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 Oct. 1947 to 8 Dec. 1947 and that I last saw him alive on 8 Dec. 1947

Immediate cause of death	DURATION
Carcinoma of Pancreas	1 yr (Dec. 46 - Dec. 47)
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. E. Marland, Jr. 12-12-47 MC USN
A. E. MARLAND, Jr., Lt JG. MC USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 12-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

488 X

11352

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery Co.
City or town: Silver Spring
(If outside city or town limits, write RURAL, NEAR and give town)
Street address, hospital, or institution: 708 Sligo Ave
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Wash. D.C. County: D C
City or town: D. C. Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 5813- 14 st N W
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Catherine A. Baldwin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6 (b) Name of husband or wife: Thomas
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-23-71

8. AGE:

Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: Rowlesburg W. Va.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business: "

FATHER 12. Name	John Mullen
FATHER 13. Birthplace	Ireland
MOTHER 14. Maiden name	Sally Reagan
MOTHER 15. Birthplace	Ireland

16. Informant: Mrs. Winifred Baldwin.
Address: 5813-14 St NW.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-29-47 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cem.
Location: Wash, D.C.

18. Funeral director: N K Huntemann
Address: 5732 Ga Ave

19. Dec 27 1947 (Date rec'd by registrar) Josephine M Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-27 1947 at 2 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15 1947 to Dec 27 1947, and that I last saw her alive on 12/26 1947.

Immediate cause of death	DURATION
Carcinoma uterus & adnexa.	3 1/2 Mo
Due to	
Due to	
Other conditions: Myocardial heart disease	6 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Generalized Carcinoma, uterus & adnexa.
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph R. Jordan MD M. D. or other
Address: 5412 Colo. Ave NW Date signed: 12/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Pa 57100

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11353

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr. Milton H. Bancroft.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Mrs. Margaret Bancroft.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~December 11 1872~~ (Jan. 1, 1866)

8. AGE:

Years	Months	Days	If less than one day
81	11	10	hrs. min.

9. Birthplace Newton, Massachusetts
(Town, county, and state)

10. Usual occupation Retired.

11. Industry or business

FATHER

12. Name Mr. William Bancroft

13. Birthplace Mt. Vernon, New Hampshire.

MOTHER

14. Maiden name Martha Barrey

15. Birthplace Lowell, Mass.

16. Informant Hospital records.

Address

17. (Burial, cremation, or removal. Which?) Burial Date thereof Dec. 13-47 (month) (day) (year)

Cemetery or crematory Cemetery

Location Friends Meeting House

18. Funeral director Mrs. Ruby Humphreys

Address Bethesda, Md.

19. Dec. 12 1947 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1947, at 5:34 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1946, to Dec. 11 1947 and that I last saw him alive on Dec. 11 1947

Immediate cause of death	DURATION
Uremia	3 days
Due to Chronic Interstitial Nephritis	2 1
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md. Date signed 12/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11354

170c

Reg. Dist. No. 245 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death: Dead on arrival
Hospital, institution, or street address where death occurred: Takoma Park Sanitarium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: DC County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3918 - 5 St NW
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2

3. (a) FULL NAME: Samuel Barberio
3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6. (b) Name of husband or wife:
6. (c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Jan 22, 1924
8. AGE: Years: 23 Months: Days: If less than one day ... hrs. ... min.
9. Birthplace: Rossiter Penn
(Town, county, and state)
10. Usual occupation: Tile Setter
11. Industry or business:

FATHER
12. Name: Dominick Barberio
13. Birthplace: Italy

MOTHER
14. Maiden name: Angelina Marisco
15. Birthplace: Italy

16. Informant: Ralph Barberio
Address: 3918 - 5 St NW

17. Removal — Date thereof: 12/25/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Washington Nat'l
Location: Washington DC

18. Funeral director: W. W. Chambers Co.
Address: 1400 Chapin St NW

19. Dec 19 ... (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24 1947, at 11^25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Hemorrhage and shock
Due to: Crushed skull and face
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op.
Autopsy results:

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident — Date of: 12-24-47
Where did injury occur: Takoma Park, P.G., Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where): New Hampshire Ave
Means of injury: Occupant of car that wrecked

Deputy medical examiner

23. SIGNATURE: James I. Boyd — M. D. or other
Address: Hyattsville Md — Date signed: 12.25.47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d+ 11355

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 8119 Georgia Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No. 8119 Georgia Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. MARGARET E. BARNES

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~XXXX~~ John T. Barnes 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1870

8. AGE: Years 77 Months 6 Days 7 If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name John E. Turner

13. Birthplace Maryland

MOTHER 14. Maiden name Augusta Clark

15. Birthplace Maryland

16. Informant Mrs. Madge E. Parsons, daughter

Address 8119 Ga. Ave., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 15, 1947 (month) (day) (year)

Cemetery or ~~XXXXXX~~ Colesville Cemetery

Location Colesville, Md.

18. Funeral director Warner E. Pumphrey

Address 8434 Ga. Ave., Silver Spring, Md.

19. Dec 15 19 47 Josephine M. Schaeffe Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 19 47 at 7:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 46 to Dec. 12 19 47 and that I last saw her alive on Dec. 12 19 47

	DURATION
Immediate cause of death Cardiovascular renal disease	?
Due to Carcinoma of Lung, Rt.	2 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank G. Zack M.D. M. D. or other

Address 8248 Ga. Ave Silver Spring Md. Date signed 12-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

11356

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 1a

CERTIFICATE OF DEATH

Reg. Diat. No. 714

1. PLACE OF DEATH:
County 6412 Western Ave
City or town Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County MONT.
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6412 Western Ave
(If rural: give LOCATION)
2.(a) If veteran, name war NONE

3.(a) FULL NAME OTTO BAUER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife KATIE BAUER
6.(c) If alive, give age 78 years
7. Birth date of deceased (mo., day, yr.) July 26 1865

8. AGE: Years 82 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Lutherville Md. (Town, county, and state)
10. Usual occupation FLORIST
11. Industry or business Flowers

FATHER
12. Name HENRY BAUER
13. Birthplace GERMANY

MOTHER
14. Maiden name ANDREWS
15. Birthplace GERMANY

16. Informant PAUL BAUER
Address 7000 Vale St Ch Ch Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9 1947 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland Prince Geo. Md.
18. Funeral director S H Hines Co
Address 2901 14th St N.W.

19. Dec 6 1947 (Date rec'd by registrar) Josephine M Schaeffle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1947 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1940, to Dec. 6 1947 and that I last saw h[illegible]m alive on Dec. 6 1947.

Immediate cause of death	DURATION
Hypertensive Cardio Vascular Renal Disease	
Due to Uremia.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE William F. Luckett M.D. (M. D. or other)
Address 5000 Reno Rd N.W. Date signed 12-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46-X 11357

CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred: Montgomery County General Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: RURAL - Brookeville (If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 97 (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: WALTER JOHNSON BEALL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marie M.
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): March 5, 1884

8. AGE: Years	Months	Days	If less than one day
63	9	11	....hrs. ....min.

9. Birthplace: Montgomery County, Md. (Town, county, and state)
10. Usual occupation: Caretaker
11. Industry or business: "

FATHER
12. Name: James H. Beall
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elizabeth Morgon
15. Birthplace: Maryland.

16. Informant: Mrs. Marie M. Beall
Address: Brookeville, Md.

17. BURIAL. (Burial, cremation, or removal. Which?) Date thereof DEC - 19 - 1947. (month) (day) (year)
Cemetery or crematory: CONGRESSIONAL
Location: WASHINGTON - DC
18. Funeral director: Warner E Pumphrey
Address: SILVER SPRING - MD.

19. 12 - 19 1947 (Date rec'd by registrar) Gertrude B Fowler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1947, at 2:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 3 1947, to Dec. 16 1947
and that I last saw him alive on Dec. 16 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	Months
with Multiple Metastases	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.: ....
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: Richard A. Yates, M.D. M. D. or other
Address: RFD # 3 Rockville, Md. Date signed: 12/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246 11358

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:
County 124 Hilltop Rd. Montgomery County
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 124 Hilltop Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME JANE HENDERSON BENGEL

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Frederick Bengel
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 27, 1867

8. AGE: Years	Months	Days	If less than one day
80	7	6	..... hrs. ..... min.

9. Birthplace Scottland (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name John Henderson
13. Birthplace Scotland

MOTHER
14. Maiden name Janet Angus
15. Birthplace Scotland

16. Informant Mrs. Mary H. Beaumont
Address 124 Hilltop Rd, Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/6/47 (month) (day) (year)
Cemetery or crematory XXXX Druid Ridge Cemetery
Location Pikesville, Md.

18. Funeral director WM. J. TICKNER & SONS INC.
Address North & Pa. Aves., Baltimore, Md.

19. 12/5 1947 A.W. Hedrick DM Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1947, at 1:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1945, to Dec. 3 1947 and that I last saw h.er alive on December 3 1947

Immediate cause of death	DURATION
Carcinoma of Liver	8-10 yrs.
Due to	
Contr. Generalized Asteroid Sclerosis	8-10 yrs.
Other conditions Pancreatitis	4 months

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE O.B. Wardrop M.D. M. D. or other
Address 943 Bonifant St., Silver Spring Date signed Dec. 3, '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-10M

11359

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery Co.

City or town Bethesda Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since → 12-11-47

Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd., Bethesda, Md.

How long in hospital or institution? since → 12-11-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8409 Dixon Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr Adolph Berggren

3.(b) Social Security Number 491-22-8391

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWED

6.(b) Name of husband ~~or wife~~ Inga Berggren (Dec.) 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1883

8. AGE: Years	Months	Days	If less than one day
64	7	10	hrs. min.

9. Birthplace Osbourne Md (Town, county, and state)

10. Usual occupation Night Watchman

11. Industry or business Canada Dry Bottling Co

FATHER 12. Name Carl Berggren

13. Birthplace Sweden

MOTHER 14. Maiden name Emma Unknown

15. Birthplace Sweden

16. Informant Mrs Roy Miller - Daughter

Address 8409 Dixon Ave - Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-21-1947 (month) (day) (year)

Cemetery or crematory Geo. Wash. Memorial

Location Riggs Rd. Prince Georges Co. Md

18. Funeral director Edward E Pumphrey Inc

Address Silver Spring - Md

19. 12/20/47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18-47 1947 at 10 50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1947, to Dec 18 1947

and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute heart failure	
Due to cardiovascular disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy (Yes or No) Results Enlargement of heart with edema of lungs & liver of op. Congenital and

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ephraim Lowrence M.D. M. D. or other

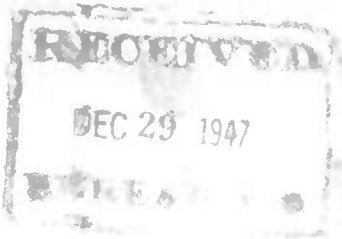
Address Suburban Hospital Date signed 19 Dec 47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mrs Gobes
5112 Maple Ridge Rd.
Bethesda



11360

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? one month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1662 Primrose Road, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: BISHOP, Emmett Cyrus

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 15, 1893

8. AGE: Years	Months	Days	If less than one day
54	6	2	hrs. min.

9. Birthplace: Leslie, Michigan
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER — 12. Name: BISHOP, Frank

13. Birthplace: N.Y.

MOTHER — 14. Maiden name: WILLIAMS, Kate

15. Birthplace: Wales

16. Informant: mo: Mrs. Kate Bishop
Address: c/o D. W. Boom houser 1662 Primrose Road, N.W., Wash., D.C.

17. burial — Date thereof (month) (day) (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 12-18 19 47 — Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17 19 47 at 11:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 19 47 to Dec. 17 19 47

and that I last saw him alive on 17 November 19 47

Immediate cause of death	DURATION
Hypertensive Heart Disease	
Due to: Chronic Nephritis	
Due to:	
Other conditions: Pyelonephritis	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

confirmed above

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. R. COOPER, Lt. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-18-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11361

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: SILVER SPRING (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred: 8017 EASTERN AVE

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. 8017 EASTERN AVE (If rural, give LOCATION)

2.(a) If veteran, name war: No.

3.(a) FULL NAME: BLOOMER WILLIAM JESSE

3.(b) Social Security Number: 214-28-2513

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	MARRIED

6.(b) Name of husband or wife: SEATON, KATE COPELAND

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): JUNE 24, 1876

8. AGE: Years: 71 | Months: 5 | Days: 25 | If less than one day: ... hrs. ... min.

9. Birthplace: MT. VERNON, KENTUCKY (Town, county, and state)

10. Usual occupation: REAL ESTATE SALESMAN

11. Industry or business: GRAHAM HALL REALTY

FATHER — 12. Name: BLOOMER, FRANCIS MARION

FATHER — 13. Birthplace: TENN.

MOTHER — 14. Maiden name: TYREE, PRIC.

MOTHER — 15. Birthplace: KENTUCKY

16. Informant: MRS. Wm J. BLOOMER

Address: 8017 EASTERN AVE

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof DEC-22-1947 (month) (day) (year)

Cemetery or crematory: FORT LINCOLN

Location: PRINCE GEORGES Co. MD

18. Funeral director: Wayne E. Humphrey

Address: SILVER SPRING MD

19. DEC 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DEC 19 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above sieled; that I attended deceased from JUNE 1938 to DEC 19 1947 and that I last saw him alive on DEC 19 1947

Immediate cause of death	DURATION
CORONARY THROMBOSIS	15½ hours.
Due to: ANGINA PECTORIS	3 WKS.
Due to: ARTERIO SCLEROSIS	6 YEARS
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. W. Mitchell M.D. M. D. or other

Address: Silver Spring, Md Date signed 12-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11362

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Rockville, R. F. D. Near Oakdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. Near Oakdale

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Beatrice Reeve Bready.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married.

6.(b) Name of husband or wife Mr. Calvin Bready

6.(c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) November 19, 1865

8. AGE: Years 82 | Months 0 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Canada

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Thomas H. Reeve

13. Birthplace Canada

MOTHER

14. Maiden name ?

15. Birthplace ?

16. Informant Mrs. Calvin Bready

Address Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-6-47 (month) (day) (year)

Cemetery or crematory Rockville Union Cem.

Location Rockville, Md.

18. Funeral director Wm Reuben Pumphrey

Address Rockville, Md.

19. Dec 6 1947 (Date rec'd by registrar) Gertrude B Fawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1947, at 9:38 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/1/47 1947, to December 3 1947 and that I last saw her alive on 11/20/47 1947

Immediate cause of death	DURATION
Acute Cardiac Failure	5 min
Due to Chronic Myocarditis	4 years
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. Bready M. D. or other

Address Sandy Spring, Md. Date signed 12/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

126 11363

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5615 Roosevelt St. Bethesda
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Breck, Mr. Lewis Tebbetts ~~Tebbetts~~

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Jean Breck
6.(c) If alive, give age 35 years
7. Birth date of deceased (mo., day, yr.) Feb. 9, 1895

8. AGE: Years	Months	Days	If less than one day
52	10	20	..... hrs. ..... min.

9. Birthplace St. Louis, Missouri (Town, county, and state)
10. Usual occupation Manager
11. Industry or business Philco Corp.
FATHER 12. Name Robert Breck
13. Birthplace St. Louis, Mo.
MOTHER 14. Maiden name Ellen Mansue
15. Birthplace New Hampshire
16. Informant Mrs Jean Breck
Address 5615 Roosevelt St. Bethesda Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31 47 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location S. W. Nunes Co
18. Funeral director
Address Wash. D.C.
19. 12/29 1947 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1947, at 4:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1947 to Dec 29 1947 and that I last saw h.. alive on Dec 29 1947

Immediate cause of death	DURATION
Bilateral Labor pneumonia	
Acute suppuration	
Due to Cholecystitis & Cholelithiasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Acute suppurative cholecystitis & cholelithiasis Date of op. 12-26-47
Autopsy results Bilateral Labor pneumonia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Thayer M. D. or other
Address Bethesda, Md Date signed 12-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

11364

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One year, two months

Hospital, institution, or street address where death occurred:

260 Maple Avenue,

How long in hospital or institution? Nursing home, 14 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 260 Maple Avenue,

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Eliza Susan Burnett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Isaac C. Burnett

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 17 1886

8. AGE: Years	Months	Days	If less than one day
61	1	14	____ hrs. ____ min.

9. Birthplace: Bedford County, Va. (Town, county, and state)

10. Usual occupation: House wife.

11. Industry or business: Home.

FATHER

12. Name: Samuel J. White

13. Birthplace: Bedford County, Va.

MOTHER

14. Maiden name: Missouri Jane Dobbins

15. Birthplace: Bedford County, Va.

16. Informant: Mrs. Eva Anderson, Neice

Address: 4108 Fairfax Ave, Landover Hills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-3-47 (month) (day) (year)

Cemetery or crematory: Washington Natl. Cemitery

Location: Suitland, md

18. Funeral director: H.W.C. Hanks Co.

Address: Riverdale, Md.

19. Dec 2 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1, 1947, at 8:35 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 16, 1947 to Dec. 1 1947

and that I last saw h.e.r alive on December 1, 1947

Immediate cause of death: Myocardial Insufficiency with Pulmonary Edema — Duration: 13 hrs.

Due to: Generalized Arteriosclerosis & Arteriosclerotic Heart Disease — Duration: 5 yrs +

Due to: ____ — Duration: ____

Other conditions: Diabetes Mellitus — Duration: 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Wallace Z. Mook M.D. M. D. or other

Address: 805 Carroll Ave. Takoma Park 12 Md. Date signed: 12-1-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coverage is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

CERTIFICATE OF DEATH

Reg. Dist. No. 2-6 — 11367

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 12-3-'47

Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd. Bethesda md.

How long in hospital or institution? Since 12-3-'47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Poolesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.R.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr James Catron Sr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
m	w	

6.(b) Name of husband or wife: Carrie E. Catron

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5, 1899

8. AGE: Years	Months	Days	If less than one day
48	7	3	hrs. min.

9. Birthplace: Tazewell Co. Virginia
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: John R. Catron
13. Birthplace: Withe Co. Virginia

MOTHER
14. Maiden name: Margaret Brown
15. Birthplace: Smith Co. Virginia

16. Informant: Mrs Carrie Catron
Address: Poolesville, Md, RFD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 10, 1947 (month) (day) (year)

Cemetery or crematory: Monocacy

Location: Beallsville, Md

18. Funeral director: William B. Hilton

Address: Barnesville, Md

19. 12/9 1947 (Date rec'd by registrar) Wm E. Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-8 1947, at 3 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiac Failure	
Due to	
Due to	
Other conditions: Peritonitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Perforated appendix & acute Suppurative appendicitis Date of op. 12-3-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W B Ford M. D. or other

Address: Suburban Hospital Date signed: 12-8-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11366

CERTIFICATE OF DEATH

Reg. Dist. No. F-16

1. PLACE OF DEATH:

County. Montgomery

City or town. Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden death

Hospital, institution, or street address where death occurred:
Opposite 331 Willard Ave.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5310 - 43 st NW
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Gale Chapman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Annie McQueen

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day hrs. min.

9. Birthplace Chew Spr., Va
(Town, county, and state)

10. Usual occupation retd shoe salesman

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden name "

15. Birthplace

16. Informant Courtney Gale Chapman

Address 5310 - 43 St

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/5/48 (month) (day) (year)

Cemetery or crematory Fairview Cemetery

Location Culpeper Va.

18. Funeral director A. H. Hines Co

Address 2901 - 14th NW

19. 1/4 1948 Mrs E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1947, at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death DEP. MED. EXAM. CASE.

Due to Coronary occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION
Imp.
Imp.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bronhart M.D.
M. D. or other

Address Dep. Med. Exam. Gaithersburg, Maryland Date signed 1/3/48

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

11367

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 yrs.
Hospital, Institution, or street address where death occurred:
15 South Wall Street
How long in hospital or Institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 15 South Wall Street
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME OSCAR BERNARD CLENDENING

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife None
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
81	81		..... hrs. ..... min.

9. Birthplace Hillsboro, Va. (Town, county, and state)
10. Usual occupation Retired Fruit Grower
11. Industry or business

FATHER
12. Name Thomas Russel Clendening
13. Birthplace Hillsboro, Va.

MOTHER
14. Maiden name Sarah Hand Balthis
15. Birthplace Clerk County, W. Va.

16. Informant Mr. Hugh R. Thompson
Address Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22, 1947 (month) (day) (year)
Cemetery or crematory Hillsboro Cemeter Company
Location Hillsboro, Virginia

18. Funeral director Wm. Reubens Sumpter
Address Rockville, Maryland

19. 12/21/47 (Date rec'd by registrar) E P Thompson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1947 at 5:10P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Dec 19 1947 and that I last saw him alive on Dec 19 1947

Immediate cause of death	DURATION
Coronary occlusion	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C E Hawkins M. D. or other
Address Rockville, Md Date signed 12/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1860

143398

11368

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Suburban Hospital
8600 Old Georgetown Rd. - Bethesda Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Kentucky County Kenton

City or town Covington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 639 W. 9th St
(If rural, give LOCATION)

2.(a) If veteran, name war Unknown

3.(a) FULL NAME Raymond Duncan Cobb

3.(b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Mary B Cox Cobb (Dec.)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 3, 1878

8. AGE: Years	Months	Days	If less than one day
69	8	23	..... hrs. ..... min.

9. Birthplace Covington Kentucky
(Town, county, and state)

10. Usual occupation retired (?)

11. Industry or business

FATHER
12. Name Sylvanus A. Cobb
13. Birthplace Union Maine

MOTHER
14. Maiden name Elizabeth Duncan
15. Birthplace Cynthiana, Kentucky

16. Informant Mildred McFarland (daughter)
Address 8508 Garfield - Bethesda Md.

17. Burial-Transit (Burial, cremation, or removal. Which?) Date thereof Dec. 27, 1947 (month) (day) (year)

Cemetery or crematory Spring Grove Cemetery

Location Cincinnati, Ohio

18. Funeral director Wm. Reuben Pumphrey

Address Bethesda, Maryland

19. 12/27/47 19.....
(Date rec'd by registrar)

Wm E Forbes
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 26, 1947 at 7 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. med. exam 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Shock	1 day
Due to Fracture of both hips	2 days
Due to.....	.....
Other conditions Exam	?

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 12-24-47

Where did injury occur? Bethesda (City or town) Mont (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fall from window Injured at work? No

23. SIGNATURE Frank J Bernhart M.D.
Dep. med. exam
M. D. or other

Address Frederick Md Date signed 12-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

128

11369

CERTIFICATE OF DEATH

Reg. Diat. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 507 Ellsworth Drive

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Collins, Mrs. Minnie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Div.

6.(b) Name of husband or wife: Mr. Chas. C. Collins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-20-1879

8. AGE: Years	Months	Days	If less than one day
68	2	14	hrs. min.

9. Birthplace: Washington, D.C.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: John Q. Adams Curtin

13. Birthplace: ?

MOTHER

14. Maiden name: Margaret Eudosia Wheeler

15. Birthplace: Maryland

16. Informant: Washington Sanitarium & Hospital

Address: Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 8, 1947 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Lincoln Rd., N.E., Wash., D.C.

18. Funeral director: Warner E. Pumphrey

Address: 8434 Georgia Ave., Silver Spring, Md.

19. Dec. 5 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 1947 at 8:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-29 1947 to 12-4 1947 and that I last saw h[illegible] alive on 12-4-47 1947

Immediate cause of death	DURATION
Acute Nephritis	
Due to: Acute Pancreatitis and Acute Hepatitis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dean H. Hardin M.D. M. D. or other

Address: 113 Carroll St. NW Washington DC Date signed: 12-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11370

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring, (Forest Glen)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:
10005 Rosensteel Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10005 Rosensteel Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Robert Conroy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
male	white	married

6.(b) Name of wife: Mary T.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 1st. 1886

8. AGE: Years	Months	Days	If less than one day
61	11	29	..... hrs. ..... min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business

FATHER
12. Name: John Conroy
13. Birthplace: Ireland

MOTHER
14. Maiden name: Anne Hogan
15. Birthplace: Ireland

16. Informant: Mrs. Mary Conroy Winter

Address: 10005 Rosensteel Ave.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Jan. 3rd. 1948
(month) (day) (year)

Cemetery or crematory: St. Johns

Location: Forest Glen, Montg. Co. Md.

18. Funeral director: Manner & Sumpter Inc.

Address: Silver Spring, Md.

19. Jan. 2, 1948 (Date rec'd by registrar) Joseph M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31, 19 47, at ? A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 31 Med Exam case 19 ..... to ..... 19 .....
and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	OURATION
Cerebral edema	
Due to acute alcoholism	2 hrs
Found dead in home.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Broccard M.D.
Dep't Med Exam.
M. D. or other

Address: Gaithersburg Md Date signed 1-1-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct figure is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11371

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MONTGOMERY

City or town BETHESDA

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? [redacted]

Hospital, institution, or street address where death occurred:

SUBURBAN HOSPITAL 8600 Old GEORGETOWN Rd Bethesda, Md.

How long in hospital or institution? 23 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town SILVER SPRING R.F.D. #3

(If outside city or town limits, write RURAL and give nearest town)

Street No. MONTGOMERY HILLS

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME JAMES MARTIN CROWN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of ~~husband~~ or wife VEENIE FRANCES CROWN

DECEASED 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 20, 1881

8. AGE:	Years	Months	Days	If less than one day
	66	8	24	..... hrs. ..... min.

9. Birthplace MONTGOMERY COUNTY, MARYLAND (Town, county, and state)

10. Usual occupation LABORER

11. Industry or business

FATHER 12. Name GEORGE CROWN

13. Birthplace MONTGOMERY Co. MD.

MOTHER 14. Maiden name REBECCA RICKETTS

15. Birthplace MONTGOMERY Co. MD.

16. Informant VIOLET HALEY - DAUGHTER

Address 142 MAPLE AVE. KENSINGTON, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 12-17-47 (month) (day) (year)

Cemetery or crematory LAYHILL METHODIST CH.

Location LAYHILL, MONTG. Co. MD

18. Funeral director Warner & Company

Address Silver Spring, Md.

19. 12/16 1947 (Date rec'd by registrar) M E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 December 1947 at 5:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 Dec. 1947, to 14 Dec. 1947

and that I last saw him alive on 14 Dec. 1947

Immediate cause of death — DURATION

1. Congestive heart failure — 2 Months

Due to 2. Pneumonia, lobar

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not Done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dan B Greer M.D. M. D. or other

Address Suburban Hospital Date signed 15 Dec 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11372

92a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4221 Edson Place, N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: DELANEY, Arthur (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	married

6.(b) Name of husband or wife: Gladys Delaney

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1895

8. AGE: Years	Months	Days	If less than one day
52	8	21	..... hrs. ..... min.

9. Birthplace: Wash., D.C.
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business: Nash-Kelv. Corp

FATHER
12. Name: Delaney, Arthur dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: Anderson, Susan dec
15. Birthplace: Md.

16. Informant: wife: Mrs. Gladys Delaney
Address: 4221 Edson Place, N.E., Wash., D.C.

17. (Burial, cremation, or removal. Which?) burial Date thereof ..... (month) (day) (year)

Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: McGuire Funeral Home J.E.M.
Address: 1820 9th St., N.W., Wash., D.C.

19. 12-24 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24 19 47 at 2:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Dec. 1947 to 24 Dec. 1947 and that I last saw him alive on 24 Dec. 1947

Immediate cause of death	DURATION
Valvular Heart Disease, Aortic Insufficiency with Congestive Failure	dnd
Due to	
Due to	
Other conditions: Arteriosclerosis, Generalized	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Confirmed Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. R. COOPER, Lt. MC USN

Address: USNH Bethesda, Md. M. D. or other

Date signed: 12-24-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

54a X

11373

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1: PLACE OF DEATH:

County Montgomery

City or town Takoma Park.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years 4 months

Hospital, Institution, or street address where death occurred:

808 Kennebec Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 808 Kennebec Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME JOSEPH HENRY DIGGS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Eva M. Diggs

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 10, 1883

8. AGE: Years	Months	Days	If less than one day
64	9	24	....hrs. ....min.

9. Birthplace Anderson County Tennessee

(Town, county, and state)

10. Usual occupation Barber

11. Industry or business Barber Shop

FATHER 12. Name William Joseph Diggs

13. Birthplace Tennessee

MOTHER 14. Maiden name Mary Grubb

15. Birthplace Tennessee

16. Informant Mrs. Eva M. Diggs

Address 808 Kennebec Ave. Takoma Park. Md.

17. Burial Date thereof Dec. 6. 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory George Washington Memorial Cemetery

Location Rock Cr. Hyattsville, Md.

18. Funeral director J. Arthur Walters

Address 254 Carroll St. Takoma Park. D.C.

19. Dec 5 1947 [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1947 to Dec 3 1947

and that I last saw h.. alive on Dec 3, 1947

Immediate cause of death	DURATION
Thrombosis of Cerebral Vessels. Arterial Hypertension	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Jan 25, 1947 — Confirmed above Date of op. —

Autopsy results None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide 0 Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas M. Holohan M. D. or other

Address 500 Underwood N.W. Date signed 12/4/47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of year of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11374

FILM No. G 113 DEC 15 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery Co.
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 756 - Sil Spring ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ray C. Sitzler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Mary V. Sitzler
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec-13-1882

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace Wellington, Del (Town, county, and state)
10. Usual occupation Brick Layer
11. Industry or business
FATHER 12. Name John H. Sitzler
13. Birthplace Covington, Ohio
MOTHER 14. Maiden name Emma F. Vernon
15. Birthplace unknown
16. Informant Mary V. Sitzler
Address 756 Sil. Spring Ave. Sil Spring Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 12-5-47 (month) (day) (year)
Cemetery or crematory Rock Creek Cemetery
Location Wash D.C.
18. Funeral director W W Chambers Co.
Address Riverdale. md.

19. Dec 3 1947 (Date rec'd by registrar) Joseph M Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-2 1947 at 8 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 1947 to Dec 2 1947 and that I last saw h.. alive on Dec 1 1947

Immediate cause of death	DURATION
Acute Congestive Failure	1 day -
Due to Advanced Pulmonary Tuberculosis	1 yr at least
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frances L Richardson M. D. or other
Address 711 Alaska Ave N. W. Date signed 12/2/47

VS A15 9-45-[illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12376 93d 11375 Reg. Dist. No. 2/6

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or Institution? 41 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Clarksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John J. Dorsey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb-8, 1903-

8. AGE: Years: 44 | Months: 10 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Jersaleum, Md- (Town, county, and state)

10. Usual occupation: Farm worker

11. Industry or business

FATHER
12. Name: Wesley Dorsey
13. Birthplace: Jersaleum, Md-

MOTHER
14. Maiden name: Julia Moore
15. Birthplace: Jersaleum, Md-

16. Informant: Mary Chaney (Sister)
Address: same

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 26-1947 (month) (day) (year)
Cemetery or crematory: Rock Hill
Location: Montgomery Md

18. Funeral director: Roy W Barbour
Address: Rockville Md

19. 12/24/47 (Date rec'd by registrar) Mrs E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 23, 1947 at 9 35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 December 1947 to 23 December 1947 and that I last saw h.i.m. alive on 23 December 1947

Immediate cause of death	DURATION
1. Hypertensive Cardio Vascular Disease with Congestive failure	Several Months
Due to: 2. Cerebral hemorrhage	2 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury ..... Injured at work?

23. SIGNATURE: Dan B Greer M.d. M. D. or other
Address: Suburban Hospital Bethesda Md Date signed: 24 Dec 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11c 11376

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
9311 Old Bladensburg Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9311 Old Bladensburg Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: MRS. CLARA A. EASTMENT

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: George W.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 19th. 1947

8. AGE: Years	Months	Days	If less than one day
81	0	21	..... hrs. ..... min.

9. Birthplace: Delmar, Iowa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Sylvanis Norton
13. Birthplace: New Hampshire

MOTHER
14. Maiden name: Elsie Dustin
15. Birthplace: New Hampshire

16. Informant: Mr. George W. Eastment, Jr.

Address: 931 Old Bladensburg Rd.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 12-13-1947
(month) (day) (year)

Cemetery or crematory: Rock Creek, Washington,

Location: Washington, D. C.

18. Funeral director: Warner E Pumphrey.

Address: Silver Spring, Md.

19. Dec 11 1947
(Date rec'd by registrar)
Josephine M Schaeffe
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 1947 at 10.57 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945 to 12-10 1947 and that I last saw h[illegible] alive on 12-10 1947

Immediate cause of death	DURATION
Pneumonia Terminal	12 hours
Cerebral Edema.	1 week.
Due to Generalized Arteriosclerosis	
Senility	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P. P. Anderson M.D
M. D. or other

Address: Washington D.C Date signed: 12-10-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52-X 11377

CERTIFICATE OF DEATH

Reg. Diat. No. 2-17

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Months
Hospital, Institution, or street address where death occurred: Montgomery Co. Gen. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hollow Tree Farm
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: JOHN O EATON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian A. Eaton
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
70 70	?	?	...hrs. ...min.

9. Birthplace: Iowa City, Iowa
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Clinton Eaton
13. Birthplace: Unknown

MOTHER
14. Maiden name: Belinda Mitcheal
15. Birthplace: Port Jarvis, New York

16. Informant: Hospital Records
Address: Montgomery County Gen. Hosp.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Dec 16/47 (month) (day) (year)
Cemetery or crematory: Cedar Hill Crematory
Location: Washington, D.C.

18. Funeral director: Wm. Loudon Humphrey
Address: Bethesda, Maryland

19. Dec 16 1947 (Date rec'd by registrar) Gertrude B. Fawley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 Dec 1947 at 4.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Nov 1947, to 14 Dec 1947 and that I last saw h[illegible] alive on 14 Dec 1947

Immediate cause of death	DURATION
Uremia	
Due to: Carcinoma	
Due to: Carcinoma of Bladder	4 yr
Other conditions: Emphysema.	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: Charles H. Ligon M.D. M. D. or other
Address: Sandy Spring Md Date signed: 12/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12241
11378
Reg. Diat. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Live
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 34 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: None
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: William Brooke Edmonston

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Vaudia
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept-12, 1875.

8. AGE: Years 72 | Months 2 | Days 27 | If less than one day ____ hrs. ____ min.

9. Birthplace: Rockville, Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: John Brooke Edmonston
13. Birthplace: Brookeville, Md-

MOTHER
14. Maiden name: Harriet D. Holt
15. Birthplace: Pa-

16. Informant: wife-
Address: same-

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/13/47 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland.

18. Funeral director: Wm. Reuben Trundle
Address: Rockville, Md.

19. 12/12 1947 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec-9, 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 Dec 1947 to 9 Dec 1947 and that I last saw him alive on 9 Dec 47 1947

	DURATION
Immediate cause of death: Coronary thrombosis	24 hrs
Due to: Arterio-sclerosis	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: W S Murphy M.D. M. D. or other
Address: Rockville Md Date signed 12 Dec 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

tr 11379

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. R#1 Box 40

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mr. Irvin Fincham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Viola Fincham

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 7, 1903.

8. AGE: Years	Months	Days	If less than one day
44	3	11	..... hrs. ..... min.

9. Birthplace Madison, Virginia

(Town, county, and state)

10. Usual occupation — Laborer

11. Industry or business

FATHER

12. Name William Fincham

13. Birthplace Virginia

MOTHER

14. Maiden name Margaret Dodson

15. Birthplace Virginia

16. Informant Hospital records.

Address

17. Burial Date thereof 12/18/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Emmanuel Cemetery

Location Scaggsville, Maryland

18. Funeral director DeWitt Dorsey & Son

Address Laurel, Md.

19. Dec 16 1947 Gertrude B Fawbush

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1947 at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to December 16 1947 and that I last saw him alive on December 16 1947

	DURATION
Immediate cause of death Cerebral Hemorrhage	1 day
Due to Cerebral Vascular disease - ?	
Diabetes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J W B

M. D. or other

Address Sandy Spring, Md. Date signed 12/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11380

CERTIFICATE OF DEATH

Reg. Dist. No. 276

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

4804 Cresent Street.,

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase.,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4804 Cresent Street

(If rural, give LOCATION)

2.(a) If veteran, name war 1st World War

3.(a) FULL NAME James B. Fineron

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret B. Fineron

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
51	7	18	..... hrs. ..... min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual occupation Accountant U.S. Government

11. Industry or business None

FATHER 12. Name Robert J. Fineron

13. Birthplace New York

MOTHER 14. Maiden name Caroline C. Mawer

15. Birthplace Chicago, Illinois

16. Informant Mrs. Fineron

Address Wife-Same

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan 2, 1948 (month) (day) (year)

Cemetery or crematory Cedar Hill Crematory

Location Washington, D. C.

18. Funeral director W. Reuben Humphreys

Address Bethesda, Maryland

19. 1/1 (Date rec'd by registrar) 19 48 Ann E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30th 19 47, at 9:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
DEP. MED. EXAM. CASE	
Due to Coronary Occlusion	Died Suddenly
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Brostart M.D. M. D. or other

Dep. Med. Exam.

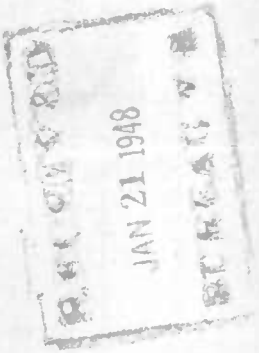
Address Gaithersburg, Maryland Date signed 12/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

513 Maple Ridge



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11381

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9805 Bristol Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gordon, Mr Charles H. N.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Mrs. Maude E. Gordon.

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 20, 1891

8. AGE:

Years	Months	Days	If less than one day
56	6	8	____ hrs. ____ min.

9. Birthplace: Georgetown, Md. (Town, county, and state)

10. Usual occupation: Building Superintendent

11. Industry or business:

FATHER — 12. Name: Charles F. Gordon

13. Birthplace: Chestertown

MOTHER — 14. Maiden name: Hattie Cunningham

15. Birthplace: Philadelphia, Penna.

16. Informant: Washington Sanitarium & Hospital

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 30, 1947 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Bladensburg Rd., Pr. Geo. Co., Md.

18. Funeral director: The S.H. Hines Co.

Address: 2401 14th St. N.W. Wash. D.C.

19. Dec 29 1947 (Date rec'd by registrar) J. William Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 28, 1947, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4, 1947, to Dec 28, 1947 and that I last saw him alive on December 28, 1947

Immediate cause of death	DURATION
Generalized carcinoma	
Due to: Carcinoma of Bladder Primary	8-10 yrs
Due to:	
Other conditions: Carcinoma of Lung (metastatic)	

(Include pregnancy within 3 months of death)

Major findings of operation: Papillary Carcinoma of Bladder grade III Date of op. 12-5-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Ferdinand Zelenko M.D. M. D. or other

Address: 835 Eye St. NW Date signed: 12-28-47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11382

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 10 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 mo., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4506 13th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWII

3.(a) FULL NAME: GRAHAM, Thomas Joseph

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 30, 1919

8. AGE: Years	Months	Days	If less than one day
28	10	27	hrs. min.

9. Birthplace: N.J.
(Town, county, and state)

10. Usual occupation: Accountant

11. Industry or business:

FATHER
12. Name: GRAHAM, Thomas
13. Birthplace: Pa.

MOTHER
14. Maiden name: McDonald, Rose
15. Birthplace: Pa.

16. Informant: Mo: Mrs. Rose Graham
Address: 4506 13th St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-31-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS J.O.P.

Address: 1400 Chapin St., N.W.

19. 12-29 19 47 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 19 47 at 7:06 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 November 19 47 to 27 Dec. 19 47 and that I last saw him alive on 27 Dec. 19 47

Immediate cause of death	DURATION
Uremia	3 Mo
Due to: Chronic glomerulo-Nephritis	4 Yrs
Due to:	
Other conditions: Hypertension Heart Disease Silicosis	6 Mo 7 Yrs

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. T. Jones, Jr. J. T. JONES, Jr., Lt.(jg) MC USNR
M. D. or other

Address: USNM Bethesda, Md. Date signed: 12-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11383

93d

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Boyds
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred:
None
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Boyds
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ELIZABETH S. GRUNEELL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Arthur Gruneell
6.(c) If alive, give age: dec. years

7. Birth date of deceased (mo., day, yr.): July 26, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	2	hrs. min.

9. Birthplace: Frederick County, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Leni Cooley
13. Birthplace: Montgomery County, Maryland

MOTHER
14. Maiden name: Caroline Thomas
15. Birthplace: Montgomery County, Maryland

16. Informant: Mrs. J. T. Reid (sister)
Address: Boyds, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31, 1947 (month) (day) (year)
Cemetery or crematory: Monocacy Cemetery
Location: Beallsville, Maryland

18. Funeral director: Wm. Reuben Dumphrey
Address: Rockville, Maryland

19. Dec. 30 1947 Alvada L. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30, 1947, at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3, 1947, to December 28 1947 and that I last saw h.ER alive on December 30, 1947

Immediate cause of death: Arteriosclerotic cardio-vascular disease. — DURATION: 5 yrs.

Due to: Rheumatoid arthritis — DURATION: 7 years.

Due to: Secondary anemia - — DURATION: Fatality.

Other conditions — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: James P. Kerr M.D. M. D. or other
Address: Damascus, Md. Date signed 12/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11384

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 hrs.
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 32 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 503 P St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HALL, Frenie Washington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	married

6.(b) Name of husband or wife: Mrs. Pinkey Hall
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 29, 1894

8. AGE: Years	Months	Days	If less than one day
53	0	16	hrs. min.

9. Birthplace: N.C. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER — 12. Name: HALL, Larkin dec
13. Birthplace: N.C.
MOTHER — 14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: wife: Mrs. Pinkey Hall
Address: 503 P St., N. W., Wash., D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-18-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: L. E. MURRAY & Son. C.H.M.
Address: 1337 10th St., N.W., Wash. D.C.
19. 12-15 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 December 19 47 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Dec. 19 47 to 15 Dec. 19 47 and that I last saw him alive on 15 December 19 47

Immediate cause of death	DURATION
Myocardial infarction	several hours
Due to: Coronary atherosclerosis	years
Due to:	
Other conditions: Cellulitis of scrotum & penis, tremor, Bronchopneumonia, (Include pregnancy within 3 months of death)	3 days.

Major findings of operations: Gs
Date of op.:
Autopsy results: Confirm above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: D. E. BILLMAN, Lt. (JG) MC USN (M. D. or other)
Address: USNH Bethesda, Md. Date signed: 12-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11385

61

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3040 South Dakota Avenue, N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME HARBERS, Herman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Elizabeth Harbers

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25, 1854

8. AGE: Years	Months	Days	If less than one day
92	11	21	hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER
12. Name: HARBERS, Herman
13. Birthplace: Germany

MOTHER
14. Maiden name: KORDLANDER, Talea,
15. Birthplace: Holland

16. Informant: wife: Mrs. Elizabeth Harbers
Address: 3040 So.Dakota Ave.,N.E.,Wash.,D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-18-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS C.J.K.

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 12-17 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 19 47 at 1:57 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12 Dec. 19 47 to 16 Dec. 19 47 and that I last saw him alive on 16 Dec. 19 47

Immediate cause of death	DURATION
Bronchopneumonia	1 wk
Due to:	
Due to:	
Other conditions: Coronary Heart Disease,	indef
Diabetes Mellitus	indef

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H R Cooper M.D. or other

Address: USNH Bethesda, Md. Date signed: 12-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11394

160c

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Birth

Hospital, institution, or street address where death occurred:

Suburban Hospital, Old. Rd.

How long in hospital or institution? Birth

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Bonnie castle

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Infant Harris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	negro	—

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-4-47 - 9 P.M.

8. AGE:

Years	Months	Days	If less than one day
			hrs. 15 min.

9. Birthplace: Bethesda Montgomery, Maryland

(Town, county and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Harold Eugene Jackson

13. Birthplace: unknown

MOTHER

14. Maiden name: Margaret Eliz. Harris

15. Birthplace: Kensington, Md.

16. Informant: Margaret Elizabeth Harris

Address: 9 Bonnie Castle Kensington

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Dec 6 1947 (month) (day) (year)

Cemetery or crematory: Suburban Hospital

Location: Bethesda, Md

18. Funeral director: A. B. Salon / Supt.

Address: Bethesda 14. md

19. 12/13 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

15

20. DATE OF DEATH: December 4 1947, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4 1947, to December 4 1947 and that I last saw her alive on December 4 1947

Immediate cause of death	DURATION
Premature separation of Placenta - Bleeding	8 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M.D. or other

Address: Suburban Hospital Bethesda Md Date signed 12-5-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

11386

CERTIFICATE OF DEATH

Reg. Diat. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 hrs. 19 min.

Hospital, institution, or street address where death occurred: Washington Sanitarium + Hosp.

How long in hospital or institution? 20 hrs. 19 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1617 N. Spring wood Drive

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Unnamed Baby Hayden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): December 2, 1947

8. AGE:

Years	Months	Days	If less than one day
			20 hrs. 19 min.

9. Birthplace: Takoma Park Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Byron Trevellyan Hayden, Jr.

13. Birthplace: Washington, D.C.

MOTHER

14. Maiden name: Mary Blanche Smeltzer

15. Birthplace: Interlmont, W. Va.

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 4, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Bladensburg Rd., Washington, D.C.

18. Funeral director: J. Arthur Dalton

Address: 254 Carroll St. N.W. Takoma Park D.C.

19. Dec 4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-3-1947 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-2-1947 to 12-7-1947 and that I last saw h. alive on 12-3-1947

Immediate cause of death	DURATION
Prematurity - (5½ mo gestation)	
Due to: Cause unknown	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.: ...

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of: ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ...

Means of injury: ... Injured at work?

23. SIGNATURE: Emma Hughes M.D. M. D. or other

Address: Takoma Park, Md. Date signed: 12-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

54 b+ 11387

S 216 Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 23 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Va. County:

City or town: Falls Church

(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 East George Mason Road

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: HAYDEN, Leona Marie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Leroy Hayden

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 16, 1900

8. AGE: Years	Months	Days	If less than one day
47	6	29	hrs. min.

9. Birthplace: Ill.

(Town, county, and state)

10. Usual occupation: Civil Service

11. Industry or business: Navy Dept.

FATHER

12. Name: MILLER, George dec

13. Birthplace: Md.

MOTHER

14. Maiden name: DEER, Sophie dec

15. Birthplace: Ill.

16. Informant: husband: Mr. Leroy Hayden

Address: 113 East George Mason Road, Falls Church, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-18-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. HINES Per. R.J.S.

Address: 2901 14th St., N.W., Wash., D.C.

19. 12-16 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 19 47 at 12:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Sept. 1947 to 15 Dec. 1947 and that I last saw her alive on 15 December 1947

	DURATION
Immediate cause of death: Bronchopneumonia	36 hrs
Due to:	
Due to:	
Other conditions: Malignant Brain tumor (astrocytoma) (Include pregnancy within 3 months of death)	18 mos.

Major findings of operations: Right Malignant temporo-Parietal tumor Date of op. 23 Sept 47

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lt. (jg) MC USNR Edgar N. Weaver M.D. M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-16-47

11388

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred: WASHington SANITARium & HOSPITAL

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: MONTgomery

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 706 ERIE AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: HEATH, Rev. Thomas C.

3. (b) Social Security Number: ~~None~~ 579-01-1491.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: HEATH, MRS. ORLENA

6.(c) If alive, give age ~~64~~ ? years

7. Birth date of deceased (mo., day, yr.): SEPTEMBER 4, 1883

8. AGE: Years	Months	Days	If less than one day
64	3	1	....hrs. ....min.

9. Birthplace: CECIL Co., MARYLAND (Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business: MINISTER.—

FATHER

12. Name: William C. HEATH

13. Birthplace: EATON. MARYLAND

MOTHER

14. Maiden name: MARGARET A. DOUGHERTY

15. Birthplace: MARYLAND

16. Informant: WASHington SANITARium + HOSPITAL

Address: TAKOMA PARK 12, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof: DEC. 1947. (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Burtonsville, Md.

18. Funeral director: Arthur L. Bellers

Address: 254 Carroll St. N.W. Takoma Park 12 D.C.

19. Dec 7 1947 (Date rec'd by registrar) J. Wilson Doth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5 1947 at 10 35 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1936 to Dec 5 1947 and that I last saw him alive on Dec 5 1947.

	DURATION
Immediate cause of death: Uremia	4 days.
Due to: Ren Arteriosclerosis & Hypertension	14 yrs
Due to: Hypertrophy prostate.	
Other conditions & Catheterism on	11/20/47.

(Include pregnancy within 3 months of death)

Major findings of operations: Resected suprapubic prostate. Date of op. 11/23/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard Thorne Smith M. D. or other

Address: 758 Carroll Ave Takoma Park Md. Date signed: 12/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97 11389

CERTIFICATE OF DEATH

Reg. Diat. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Dickerson (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County: —

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 502 I St. S. W. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Addie Steffner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: John I Steffner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 1 - 1872

8. AGE:

Years	Months	Days	If less than one day
75	10	24	..... hrs. ..... min.

9. Birthplace: Monty. Co. Maryland (town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER

12. Name: Donald Welling

13. Birthplace: Maryland

14. Maiden name: Upshaw

15. Birthplace

16. Informant: Mrs. Paul Roberson

Address: Dickerson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-27-47 (month) (day) (year)

Cemetery or crematory: Manocacy

Location: Buckeystown, Md.

18. Funeral director: Wm. B. Hilton

Address: Barnesville, Md.

19. Dec. 26 1947 (Date rec'd by registrar) Mrs. C.C. Hilton By Mrs. W. B. H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1947, at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 3 1947, to Dec 25 1947 and that I last saw h.. alive on Dec 25 1947

Immediate cause of death	DURATION
Acute pulmonary edema	6 hrs.
Due to: Myocardial failure	?
Due to:	
Other conditions: Generalized arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. H. Adams M. D. M. D. or other

Address: Poolesville, Md. Date signed 12/26/47

11390

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, Institution, or street address where death occurred:
Suburban Hospital, Bethesda, Maryland
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6001 Wilson Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Jeannette Davidson Herndon

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Henry Herndon
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 4, 1869

8. AGE: Years	Months	Days	If less than one day
78	9	25	..... hrs. ..... min.

8. Birthplace: Bullock's Creek, South Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel Luck Davidson
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Nancy Walker
15. Birthplace: Waterford, Miss.

16. Informant: Eleanor H. McKeithen
Address: 6001 Wilson Lane, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31, 1947 (month) (day) (year)
Cemetery or crematory: York, South Carolina Cem.
Location: York South Carolina

18. Funeral director: W.M. Landon Pumphrey
Address: Bethesda, Maryland

19. Dec 29 47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 December 1947, at 8 35 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 December 1947, to 29 December 1947 and that I last saw her alive on 28 December 1947

	DURATION
Immediate cause of death: Pneumonia - Right - Base Lobe.	2 days
Due to: Cardiac Decompensation & Passive Congestion -	1 month
Due to: Cardiac Hypertrophy & Arterial Hypertension -	one year?
Other conditions: - Arterial Sclerosis -	

(Include pregnancy within 3 months of death)

Major findings of operation: None -
Date of op. .....
Autopsy results: None performed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John H. Bell M. D. or other
Address: 7936 Georgetown Rd Beth. Md. Date signed: 29 Dec '47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11391

Reg. Dist. No. 218

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

1. PLACE OF DEATH:
County: Montg Co,
City or town: Derwood Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montg.
City or town: Derwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Cornelius Higgins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Goldie D Higgins
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): May 8th 1909

8. AGE: Years	Months	Days	If less than one day
38	7	17	hrs. min.

9. Birthplace: Montg Co, Md,
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: Charles H, Higgins
13. Birthplace: Md,

MOTHER
14. Maiden name: Marsha Jane Watkins
15. Birthplace: Md,

16. Informant: Alvin E Higgins
Address: Derwood Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 27 47 (month) (day) (year)
Cemetery or crematory: FLOWER HILL CEMETERY
Location: Redland .Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg. Md,

19. Dec 26 1947 (Date rec'd by registrar) Rhoda G Poole Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 19 47, at 12:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25 19 47 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
1st. 2nd & 3rd degree burns involving over 90% of body	
Due to (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of 12-25-47
Where did injury occur? Derwood (City or town) Montg (County) md (State)
Injured at home, farm, industry, public place (where?) home
Means of injury fire Injured at work? no

23. SIGNATURE: Frank J. Bowchat M. D.
Dep med Exam. M. D. or other
Address: Gaithersburg md Date signed 12-26-47


RECEIVED
DEC 31 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11392

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1 Anacostia Road, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HOCKNEY, George William

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Etta Hockney
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 23, 1883

8. AGE: Years	Months	Days	If less than one day
64	4	11	hrs. min.

9. Birthplace: England (Town, county, and state)
10. Usual occupation: Retired Marine Corps
11. Industry or business

FATHER
12. Name: HOCKNEY, David dec
13. Birthplace: England

MOTHER
14. Maiden name: HARDIE, Mary dec.
15. Birthplace: England

16. Informant: Wife: Mrs. Etta Hockney
Address: 1 Anacostia Road, S.E., Wash., D.C.

17. buiral (Burial, cremation, or removal. Which?) Date thereof: 12-9-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS, a.P.
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 12-5 (Date rec'd by registrar) 1947 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 December 1947, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 Nov. 1947, to 4 Dec. 1947 and that I last saw him alive on 4 Dec. 1947

Immediate cause of death	DURATION
Bronchopneumonia	7 days.
Due to: Bronchiectasis	Indefinite
Due to:	
Other conditions: Central Thrombosis	10 days.

(Include pregnancy within 3 months of death)

Major findings of operations: None -
Date of op.:
Autopsy results: Same as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wade H. Boswell W. H. BOSWELL, Lt. MC USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 12-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11393

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Monty

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

2002 Rockwood Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2002 Rockwood Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John H Horney

3.(b) Social Security Number 220-01-0371

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 2 1898

8. AGE:

Years	Months	Days	If less than one day
49	5	23	..... hrs. ..... min.

9. Birthplace: La Plata Md (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business

FATHER

12. Name: Robert P Horney

13. Birthplace: Balto Md

MOTHER

14. Malden name: Lucinda C. Hindle

15. Birthplace: Charles Co. Md

16. Informant: Robert A Horney

Address 2002 Rockwood Rd. Silver Spring Md

17. Burial + (Burial, cremation, or removal. Which?) Date thereof 12-25-47 (month) (day) (year)

Cemetery or crematory: Rural New Cathedral Cemetery

Location: Baltimore, Md.

18. Funeral director: Wm Reuben Pumphrey

Address: Bethesda, Md

19. Dec. 24 1947 (Date rec'd by registrar) Josephine M Schaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 19 47, at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Coronary occlusion

	DURATION
Due to:	
Due to:	
Other conditions: Acute alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other

Address: Gaithersburg Md Date signed 12-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11395

CERTIFICATE OF DEATH

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: BETHESDA (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? APRIL 1924

Hospital, institution, or street address where death occurred: CONVENT OF ~~[illegible]~~ THE VISITATION

How long in hospital or institution? 23 YRS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: BETHESDA (If outside city or town limits, write RURAL and give nearest town)

Street No. 9001 - OLD GEORGETOWN RD (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SISTER MARY de CHANTAL (MARY L. HOWARD)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MARCH 25, 1874

8. AGE:

Years	Months	Days	If less than one day
73	8	20	hrs. min.

9. Birthplace: HALIFAX, N.S. (Town, county, and state)

10. Usual occupation: RELIGIEUSE

11. Industry or business:

FATHER

12. Name: JOHN HOWARD

13. Birthplace: NOVA SCOTIA

MOTHER

14. Maiden name: SUSAN CHARLTON

15. Birthplace: NOVA SCOTIA

16. Informant: SISTER MARY JOSEPH

Address: CONVENT OF THE VISITATION, BETHESDA MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: DEC 17, 1947 (month) (day) (year)

Cemetery or crematory: Convent Cemetery

Location: Bethesda, Maryland

18. Funeral director: Francis J. Collins

Address: 3821-14th St. N.W. Wash. D.C.

19. 12/17 1947 (Date rec'd by registrar) Wm E Forbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1947 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1940 to December 15 1947 and that I last saw h.. alive on December 14 1947

Immediate cause of death	DURATION
Heart Failure due to Hypertension	3 yrs.
Due to: Heart Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Michael J. McInerny M.D. M. D. or other

Address: 1150 Conn. Ave. Washington D.C. Date signed: 12-15-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

520 X

11396

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 12 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ky. County: Louisville

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Home Life Building, Louisville, 2, Ky.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: IASIGI, Loir

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 15, 1892

8. AGE: Years 54 | Months 11 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Mass.
(Town, county, and state)

10. Usual occupation:

11. Industry or business: US General Accounting

FATHER
12. Name: IASIGI, Thomas dec.
13. Birthplace: Mass.

MOTHER
14. Maiden name: JANNY, Alice M. dec.
15. Birthplace: Md.

16. Informant: cousin: Mrs. Marshall Bullitt

Address: Ky. Home Life Bldg., Louisville, 2, Ky.

17. (Burial, cremation, or removal. Which?) burial Date thereof: 12-5-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS #31- W.J.T.

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 12-3 (Date rec'd by registrar) 1947 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 1947 at 9: P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20 1947 to 2 Dec 1947 and that I last saw him alive on 2 December 1947

Immediate cause of death	DURATION
Hypernephroma with necrosis and metastases and overwhelming toxemia	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. E. FITZGERALD, Lt. JG MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160C

11397

CERTIFICATE OF DEATH

Reg. Diat. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County Montgomery County

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Washington San.t Hosp.

How long in hospital or Institution? 4 hrs, 22 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland DC. County D.C.

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6914 5th st NW

(If rural, give LOCATION)

2.(a) If veteran, name war V

3. (a) FULL NAME

~~Baby Boy~~ Paul Jamison

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-11-47

8. AGE: Years | Months | Days | If less than one day: 4 hrs. 22 min.

9. Birthplace Takoma Park, Montgomery, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Jamison, John Grantly

13. Birthplace Maryland

MOTHER

14. Maiden name Ross, Lucy Bishop

15. Birthplace Bassett, Va.

16. Informant Pts Mother, Mrs Lucy Jamison

Address 6914 5th st. N.W.

17. Burial Date thereof Dec. 17-1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sea. Fnd. Memorial

Location Spartanville Md. R.F.D.

18. Funeral director Arthur Walters

Address 254 Carroll Takoma Park Md

19. Dec 17 19 47

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 19 47 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-11-19 47 to 12-11-19 47

and that I last saw h... alive on 12-7-19 47

Immediate cause of death	DURATION
Prematurity - gestation at 6½ mo.	
Due to Premature separation placenta	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emma Hughes M.D

M. D. or other

Address Takoma Park Md. Date signed 12-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11398

Reg. Dist. No. 253

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hrs.

Hospital, Institution, or street address where death occurred: Washington Sanitarium + Hosp.

How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County: —

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3904 — 2nd St. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME ~~Edna Mae~~ Unnamed Baby Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	—

B.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 3, 1947

8. AGE: Years | Months | Days | If less than one day: 11 hrs. 59 min.

9. Birthplace: Takoma Park, Md.

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: William Ashby Johnson

13. Birthplace: Culpepper, Virginia

MOTHER — 14. Maiden name: Mary Elizabeth Marmaduke

15. Birthplace: Virginia

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 5 1947 (month) (day) (year)

Cemetery or crematory: George Washington Memorial Cemetery

Location: Riggs Road, Hyattsville, Md.

18. Funeral director: J. Carter Walters

Address: 254 Carroll Ave. Takoma Park, D.C.

19. Dec 5 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 - 3 - 1947, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3, 1947, to Dec. 3, 1947 and that I last saw h[illegible] alive on Dec. 3, 1947

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Herman I. Slate, Md.

Address: 1008 N. Highland St. Arlington, Va. M. D. or other

Date signed: 12-4-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11795 X 462 (S) 11399

Reg. Dist. No. 16

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since 10-25-47
Hospital, institution, or street address where death occurred: Suburban Hosp 8600 Old Georgetown Rd., Bethesda Md.
How long in hospital or institution? since 10-25-47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Takoma P.K. D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 617 Farragut St N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs May M Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6. (illegible), widowed, (illegible)
F	W	

6.(b) Name of husband or wife: Wm. H. Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1874

8. AGE: Years	Months	Days	If less than one day
73		2	..... hrs. ..... min.

9. Birthplace: Front Royal Virginia (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER 12. Name: Edward A. Green
13. Birthplace: Front Royal Virginia
MOTHER 14. Maiden name: Eliz. Leary
15. Birthplace: Front Royal Virginia
16. Informant: Mrs. Virginia Williams
Address: 445 Allison St. NW Wash. D.C.
17. Burial (Burial, cremation or removal. Which?) Date thereof 12-6-47 (month) (day) (year)
Cemetery or crematory: Rock Creek Memorial Park
Location: Rock Creek, Virginia
18. Funeral director: Jos. Gawler's Sons
Address: 1730 Va. Ave. N.W. Wash. D.C.
19. 12-5-47 19..... (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1947, to 12-3 1947
and that I last saw h.. alive on 12-3 1947

Immediate cause of death	DURATION
Broncho-Pneumonia	
Due to Ca. of Colon (Sigmoid)	
Due to Peritonitis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Cancer of Colon (Sigmoid)
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Dr. J. R. Coleman M.D.
M. D. or other
Address 1935 Eye St. NW Wash DC Date signed 12/3/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

5 1/2 Maple Ridge Rd

11400

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Monty.

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yr

Hospital, Institution, or street address where death occurred:

819 Inolet Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 819 Inolet Place

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alice C. D. Jordan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	married

6.(b) Name of husband or wife: Paul W. Jordan

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 29th, 1890.

8. AGE: Years	Months	Days	If less than one day
57	9	6	..... hrs. ..... min.

9. Birthplace: New York City

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Louis Stevens

13. Birthplace: New York

MOTHER

14. Maiden name: Katherine Tallman

15. Birthplace: New York

16. Informant: Mr Paul W Jordan.

Address: 819 Inolet Place Silver Spring

17. Transportation or Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 6th 1947 (month) (day) (year)

Cemetery or crematory: Silver Mount

Location: Staten Island - Richmond Co. N.Y.

18. Funeral director: Warner E. Pumphrey.

Address: Silver Spring, Md.

19. Dec 5 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6 1947, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1947, to Dec 6 1947

and that I last saw h... alive on Dec 5 1947

Immediate cause of death — DURATION

Coronary occlusion — died suddenly

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Coroner's Med. Exam. M. D. or other

Address: Frederick Md. Date signed: 12-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11401

181

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or Institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: P.G. Co.
City or town: Bradberry Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5113 W St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WWII ✓

3.(a) FULL NAME: JORDAN, Frank Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Dorothy C. Jordan
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 27 March 1914

8. AGE: Years	Months	Days	If less than one day
33	8	11	..... hrs. ..... min.

9. Birthplace: Mass. (Town, county, and state)
10. Usual occupation: US Marine Corps
11. Industry or business:

FATHER
12. Name: JORDAN, Frank Thomas
13. Birthplace: Mass.

MOTHER
14. Maiden name: WHALEN, Anna
15. Birthplace: Ireland

16. Informant: Wife: Mrs. Dorothy C. Jordan
Address: 5113 W St., Bradberry Heights, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-11-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: W. W. CHAMBERS
Address: 517 11th St., S.E., Wash., D.C.

19. 12-8 (Date rec'd by registrar) 19 47 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 December 19 47 at 4:43 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 December 47 to 8 December 19 47
and that I last saw him alive on 6 December 19 47

DEPUTY MEDICAL EXAMINER CASE

Immediate cause of death	DURATION
Burns, Multiple 2 & 3° degrees (covering over 50% of body)	35 hrs.
Due to: Gasoline Explosion	
Due to:	
Other conditions: Shock - Primary & Secondary Pulmonary Edema (Include pregnancy within 3 months of death)	35 hrs. Terminal

Major findings of operations: None ..... Date of op. .....
Autopsy results: Confirmed above diagnosis.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide, or homicide~~ Date of 6 Dec 1947
Where did injury occur? Bradberry Heights, Md. (City or town) (County) (State)
Injured at home, ~~farm, industry, public place (where?)~~ 5113 W St., (home)
Means of injury: Gasoline Explosion Injured at work? No

23. SIGNATURE: Frank J. Broschart M.D.
Frank J. BROSCHART, Dep. Med. Exam. M. D. or other
Address: Gaithersburg, Md. Date signed 12-8-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11402

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Montgomery
City or town: Kensington, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, Institution, or street address where death occurred:
Newport Mill Road, Kensington, Md.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Newport Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME Francis D. Keller

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years	Months	Days	If less than one day
69	11	7	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Charles S. Keller
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Mary E. Brand
15. Birthplace: Henderson, Kentucky

16. Informant: Mrs. Eloise T. Mc Conville
Address: 5018 Saratoga, Ave.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Dec. 24, 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Road, Suitland, Md.

18. Funeral director: W. Reuben Cumpston

Address: 7557 Wisconsin, Ave. Bethesda, Md.

19. Dec. 24th 19 47 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/47 19.... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/18/47 19.... to 12/23/47 19....
and that I last saw him alive on 12/20/47 19....

Immediate cause of death: "Coronary Thrombosis"

DURATION: 1

Due to: Arteriosclerosis Generalized & Coronary Focalization severe

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: /

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: / Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel Allen - M.D.
M. D. or other

Address: Kensington Md. Date signed 12/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11403

1250

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Staunton
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1004 N. Augusta St.,
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: KNOWLES, Paul Duncan, AOM3c USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 11, 1923

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
24	3	17		

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: US Navy

11. Industry or business:

FATHER
12. Name: KNOWLES, Lacey Lee
13. Birthplace: Va.

MOTHER
14. Maiden name: DUNCAN, Anna Lee
15. Birthplace: Va.

16. Informant: Mo: Mrs. Anna Knowles
Address: 1004 N. Augusta St., Staunton, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Thornrose Cemetery

Location: Staunton, Va.

18. Funeral director: W. W. CHAMBERS CO.

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 12-29 (Date rec'd by registrar) 47 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 19 47 at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Dec. 19 47 to 28 Dec. 19 47 and that I last saw him alive on 28 December 19 47

Immediate cause of death	DURATION
Hemorrhage, Pulmonary	24 hours
Due to Hemorrhagic diathesis,	8 days
Due to Livernecrosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. A. DINSMORE, Jr., LCDR MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-29-47

11404

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH
County: Montgomery
City or town: Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hr
Hospital, institution, or street address where death occurred: Wash San Hosp.
How long in hospital or institution? The

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4113 Fessenden N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME William Kuhns

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie B. Kuhns
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Jan 8 - 1869

8. AGE:

Years	Months	Days	If less than one day
78	11	3	...hrs. ...min.

9. Birthplace: Barto, Berks Co. Penna (Town, county, and state)
10. Usual occupation: retired engineer
11. Industry or business

FATHER
12. Name: PETER KUHNS
13. Birthplace: BARTO, PA.

MOTHER
14. Maiden name: ELIZABETH -?
15. Birthplace: BARTO PA.

16. Informant: Mrs Bessie B. Kuhns
Address: 4113 Fessenden N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-15-1947 (month) (day) (year)
Cemetery or crematory: Hanoverdale
Location: Hanoverdale, Pa.
18. Funeral director: Joseph Sawler's Sons
Address: 1754 Penna Ave. N.W.
19. Dec 11 1947 (Date rec'd by registrar) J. Thomas Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11 1947 at 6 55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to Dec 11 1947 and that I last saw him alive on Dec 11 1947

Immediate cause of death	DURATION
Coronary occlusion	1 day
" "	10 "
Due to: Cardiovascular Hypertension	
Due to: Uremia	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Howard T. Snoke M.D. M. D. or other
Address: 4 Laurel Ave Takoma Park md Date signed 12/11/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

'11463
61

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town 6310 Glenbrook Rd - (If outside city or town limits, write RURAL and give nearest town)
Street No. Bethesda (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Clara K. Laws
3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife Archer (deceased)
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1864
8. AGE: Years 83 Months Days If less than one day hrs. min.
9. Birthplace Harrisburg, Pa. (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name William Knoche
13. Birthplace Germany
MOTHER 14. Maiden name Sarah
15. Birthplace England
16. Informant William K. Laws (son)
Address same
17. Burial Date thereof 12/29/47 (month) (day) (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory Dayn Pa
Location
18. Funeral director Chevy Chase Fun'l Home
Address 5103 Wis Ave N.W.
19. 12-24 1947 W E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23, 1947, at 5:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to Oct 1947
and that I last saw her alive on Dec 23 1947

	DURATION
Immediate cause of death: Hypertensive Heart Disease	3 yrs. +
Due to	
Due to	
Other conditions: Diabetes Mellitus	3 yrs. +

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Karl [illegible] M.D. M. D. or other
Address 3130 Wis. Ave Date signed 12/23/47

11745

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1700

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Lee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Henrietta Lee
6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
54			hrs. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)
10. Usual occupation laborer
11. Industry or business

FATHER
12. Name William Lee
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden name Frances Smith
15. Birthplace Howard Co. Md

16. Informant Henrietta Lee
Address Rockville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 26. 1947 (month) (day) (year)
Cemetery or crematory Howard Chapel
Location Unity Md
18. Funeral director Robert L. Snowden
Address Rockville Md
Ed Simpson B Day
19. 12-26-47 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 19 47 at 6:40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22 19 47 to 19
and that I last saw h alive on 19
Immediate cause of death Hemorrhage due To Fracture of skull — DURATION: Instantly
Due to
Due to
Other conditions Fracture of both legs
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 12-22-47
Where did injury occur? Rockville (City or town) Montg (County) Md (State)
Injured at home, farm, industry, public place (where?) highway - Route 240
Means of injury auto Injured at work? no

23. SIGNATURE Frank J. Bosehart M.D.
M. D. or other
Address Gaithersburg Md Date signed 12-22-47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JAN 17 1948
17 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11406

Reg. Diat. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium + Hospital

How long in hospital or institution? from Nov 28/1947 to Dec 11/1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington, DC
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1720 Saratoga St NE Wash. D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Mrs Mildred Mae Light

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fe	cauc.	married

6.(b) Name of husband ~~or wife~~: John W. Light

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Feb. 19- 1888

8. AGE:

Years	Months	Days	If less than one day
59	9	22	..... hrs. ..... min.

9. Birthplace: Haydenville, Mass.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Alvin B. ~~Koonce~~ Thatcher

13. Birthplace: Beaverdam, Wis.

MOTHER

14. Maiden name: Mary Connell

15. Birthplace: Haydenville, Mass.

16. Informant: Patient's Chart

Address: Washington Sanitarium + Hospital

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12/11/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D. C.

18. Funeral director: Martin W. Tyeong Co.

Address: 1300 "N" St. N.W. Wash. D.C.

19. Dec 11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11 1947 at 6:54 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 28 1947 to Dec. 11 1947 and that I last saw h.e.w. alive on Dec. 11 1947

Immediate cause of death	DURATION
Congestive heart failure	6 mos.
Due to: Arteriosclerotic heart disease	yrs. ?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Russell A. Quinn, M.D.
M. D. or other

Address: Washington San. + Hosp. Takoma Pk. D.C. Date signed: 12/16/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11497

83a

SB

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ½ hour

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? ½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 345 11th St.,S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: LONG, John Stephen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Mrs. Ruth B. Long

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 19, 1909

8. AGE: Years	Months	Days	If less than one day
38	2	16	hrs. min.

9. Birthplace: Georgia (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Naval Gun Factory, Wash., D.C.

FATHER
12. Name: LONG, Bennett A.
13. Birthplace: Ga.

MOTHER
14. Maiden name: TUCKER, Mary Lou dec
15. Birthplace: Ga.

16. Informant: Wife: Mrs. Ruth B. Long
Address: 345 11th St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-8-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Washington, D.C.

18. Funeral director: W. W. CHAMBERS a. P.
Address: 517 11th St., N.E., Wash. D.C.

19. 12-5- 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 December 19 47 at 10: A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5 Dec. 19 47 to 5 Dec. 19 47 and that I last saw him alive on 5 Dec. 19 47

Immediate cause of death	DURATION
Hemorrhage, cerebral	1½ hrs
Due to: Hypertension, arterial	1 yr
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none - not permitted

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. L. FLECK, Lt. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11408

108

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or Institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 323 7th St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: LOVE, Mason Lee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married (separated from wife)

6.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 4, 1899

8. AGE: Years	Months	Days	If less than one day
48	1	7	hrs. min.

9. Birthplace: Tenn.
(Town, county, and state)

10. Usual occupation: unemployeed

11. Industry or business: Printer by trade

FATHER 12. Name: LOVE, Charlie dec

13. Birthplace: Tenn.

MOTHER 14. Maiden name: REYNOLDS, Laura

15. Birthplace: Va.

16. Informant: son: Mr. Delbert E. Love

Address: 323 7th St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: W. W. CHAMBERS Reg #48

Address: 517 11th St., S.E., Wash., D.C.

19. 12-11 (Date rec'd by registrar) 19 47 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 December 19 47 at 8:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 19 47 to 11 Dec. 19 47 and that I last saw h... im alive on 11 December 19 47

	DURATION
Immediate cause of death: Coma Pneumonia	3 days
Due to:	
Due to:	
Other conditions: Hypostatic Pneumonia (Include pregnancy within 3 months of death)	incipient

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. E. Billman D. E. BILLMAN, Lt. JG MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-11-47

11409

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R # 1 Inc.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Robert A. Lukens

3.(b) Social Security Number 214-03-9111

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Catherine Lukens

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) June 21, 1908

8. AGE: Years	Months	Days	If less than one day
39	5	24	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation CONTRACTOR

11. Industry or business

FATHER

12. Name Henry Lukens

13. Birthplace EICHORN Germany

MOTHER

14. Maiden name UNKNOWN.

15. Birthplace EICHORN - Germany

16. Informant Hospital records

Address

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof DEC 17 - 1947 (month) (day) (year)

Cemetery or crematory COLESVILLE METHODIST CHURCH.

Location COLESVILLE, MONTG. Co. MD

18. Funeral director Waxner & Pumphrey

Address SILVER SPRING - MD.

19 Dec 17 1947 (Date rec'd by registrar) Gertrude B Fawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1947 at 10:34 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1947, to Dec. 15 1947 and that I last saw him alive on December 15 1947

Immediate cause of death	DURATION
Acute cardiac insufficiency	2 days
Due to Hypertension - Cardio-	
Vascular disease	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Sandy Spring Md Date signed 12/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

11410

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Suburban

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 236 Great Falls, Road

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Mr. Amos W. Magruder

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Mollie W. Magruder

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1850

8. AGE: Years 97 | Months 0 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace Bethesda, Montg., Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Farmer

FATHER 12. Name Samuel W. Magruder

13. Birthplace Montgomery Co., Maryland

MOTHER 14. Maiden name Riley

15. Birthplace Montgomery Co., Maryland

16. Informant Suburban Hospital Records

Address Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 12, 1947 (month) (day) (year)

Cemetery or crematory Mt. Zion Cemetery

Location Bethesda, Maryland

18. Funeral director Wm. Reuben Pumphrey

Address Rockville, Maryland

19. Dec. 12th, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1947, at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 22, 1947 to Dec. 10th 1947 and that I last saw h.im alive on December 10th 1947

Immediate cause of death	DURATION
Bronchopneumonia	
Due to Mixed infection	
Due to	
Other conditions Fracture hip	

(Include pregnancy within 3 months of death)

Major findings of operations Fracture hip Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 24 November 1947

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Slipped on floor Injured at work? [illegible]

23. SIGNATURE Philip C. Pelland M.D. M. D. or other

Address 900 - 16th NW. Wash DC. Date signed 11 Dec 47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11411

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 403 Garland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MANLEY, Dorothy P.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Alan F. Manley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 1, 1913

8. AGE: Years	Months	Days	If less than one day
34	3	20	hrs. min.

9. Birthplace: W.Va. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Eulainne Struve
13. Birthplace: Ky.

MOTHER
14. Maiden name: John B. Payne
15. Birthplace: W.Va.

16. Informant: husband: CRE A. F. Manley, USN
Address: Naval School of Electronic Materiel, Treasure Island, Calif.

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Columbia Gardens
Location: Arlington, Va.

18. Funeral director: Ives Funeral Home
Address: 2847 Wilson Blvd., Arl., Va. N.C.D.

19. 12-22-47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 December 1947, at 10:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Dec. 1947 to 21 Dec. 1947 and that I last saw h. d.w. alive on 21 Dec. 1947

Immediate cause of death	DURATION
Hypertension Arterial	5 yrs
Due to: Uremia due to Nephrosclerosis	3 wks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. T. Fowler Jr
J. T. FOWLER, Jr., Cdr. MC USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 12-22-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47f +

11412

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, R. 2, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 11-24-47 1 mon 7 days

Hospital, institution, or street address where death occurred:
Washington San. & Hosp.

How long in hospital or institution? 11-24-47 1 mon. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington D.C
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 324 D. St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Harry R. Mann

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mrs. Marion H. Mann.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 10, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	21	..... hrs. ..... min.

9. Birthplace: Albany N.Y.
(Town, county, and state)

10. Usual occupation: .....

11. Industry or business: .....

FATHER — 12. Name: Henry Mann

13. Birthplace: Albany, N.Y.

MOTHER — 14. Maiden name: Sarah I. Smith.

15. Birthplace: Albany, N.Y.

16. Informant: Hospital Records

Address: .....

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-5-48 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cem.

Location: Wash., D.C.

18. Funeral director: A. Wm. Lee Son Co.

Address: 306 4 St. N.W.

19. 1/1 1948 (Date rec'd by registrar) Wm Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 1947 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to Jan 1 1948

and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Carcinoma of mediastinum with metastases	1 year
Due to	.....
Due to	.....
Other conditions: arteriosclerosis, prostatitis (Include pregnancy within 3 months of death)	unknown

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Henry G. Hadley M.D. or other

Address: 1252 16th St NW Date signed: Jan 6 48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or illegible is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11413

932

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 19 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. Wardman Park Hotel, Conn.Ave., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: MATHEWS, James Thomas

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Isabelle J. Mathews

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6 November 1891

8. AGE: Years	Months	Days	If less than one day
56	1	8	hrs. min.

9. Birthplace: S.C.
(Town, county, and state)

10. Usual occupation: Retired Navy

11. Industry or business:

FATHER
12. Name: MATHEWS, James T. dec.
13. Birthplace: S.C.

MOTHER
14. Maiden name: WILLIAMS, Ellen Dec.
15. Birthplace: S.C.

16. Informant: wife: Mrs. Isabelle J. Mathews
Address: Wardman Park Hotel, Conn.Ave., N.W. Washington, D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-17-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Joseph Gawler Sons R.J.H.
Address: 1756 Penn.Ave., N.W., Wash., D.C.

19. 12-15 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1947 at 10:43A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 October 1947 to 14 Dec. 1947 and that I last saw him alive on 14 Dec. 1947

Immediate cause of death	DURATION
Infection, pulmonary	1 day.
Due to: Coronary heart disease arteriosclerotic with thrombosis and myocardial infarction and mural thrombus	8-1-47
Due to: Generalized arteriosclerosis	1941
Other conditions: Hypertension arterial	1941

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Flint C. Jarrett M. D. or other

Address: USNH Bethesda, Md. Date signed 12-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95k S 11414

CERTIFICATE OF DEATH

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or Institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 837 Shepherd St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: MC DERMOTT, Hugh Oswell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Sadie McDermott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 9, 1896

8. AGE: Years	Months	Days	If less than one day
51	8	10	..... hrs. ..... min.

9. Birthplace: W.Va.
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER
12. Name: MC DERMOTT, Hugh A. dec.
13. Birthplace: W.Va.

MOTHER
14. Maiden name: BOSWELL, Carrie dec.
15. Birthplace: W.Va.

16. Informant: wife: Mrs. Sadie McDermott
Address: 837 Shepherd St., N.W., Wash., D.C.

17. burial
(Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory:

Location: Covington, Va.

18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 12-19 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 19 47 at 4:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Dec. 19 47 to 19 Dec. 19 47 and that I last saw him alive on 19 Dec. 19 47

Immediate cause of death	DURATION
cerebral embolism	6 days
Due to: subacute bacterial endocarditis	indef
Due to: Rheumatic heart disease	indef
Other conditions: Broncho-pneumonia	5 days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. D. Nies
R. D. NIES, Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1310 11415

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs
Hospitnl, Institution, or street nddress where death occurred:
How long in hospitnl or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Mont.
City or town: Kensington, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2706 - Mc Comas Ave
(If rural, give LOCATION)
2.(a) If vetcran, nnme war

3.(a) FULL NAME PHILIP M. McKIM

3.(b) Social Security Number

4. Sex	5. Color or nce	8.(a) Single, married, widowed, or divorced
M	W	WIDOWER

8.(b) Name of husband or wife: LIZABETH MACKBEE
8.(c) If alive, give nge ..... years

7. Birth dnte of decensed (mo., day, yr.): Nov 25 1867

8. AGE: Yenrs 80 | Months | Days | If less thnn one dny ..... hrs. ..... min.

9. Birthplace: New York city N.Y. (Town, county, and state)
10. Usual occupation: Clerk Retired
11. Industry or business

FATHER
12. Name: Philip Mc Kim
13. Birthplace: Ireland.

MOTHER
14. Maiden name: Selina Dakin
15. Birthplace: England

16. Informnnt: Doris H. Mc Kim
Address: 2706 Mc Comas ave Ken. Md

17. Burial (Burial, cremstion, or removal. Which?) Date thereof 12 9 1947 (month) (day) (year)
Cemetery or crematory: Glenwood.
Location: Wash. D.C.
18. Funeral director: Joseph Gawler Sons
Address: 1756 - Pa. Ave. NW.

19. 12/8 1947 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 7 1947, at 1:30 P M

21. I CERTIFY that death occurred on the dnte nbove stnted; that I attended decensed from Dec. 4 1947, to Dec. 7 1947
nnd thnt I last saw h.im alive on Dec. 7 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 Hrs.
Due to: Cardio-Vascular Renal Disease	10 Yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Dnte of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If denth was due to external cnuses, fill in the following:
Accident, suicide, or homicide: ..... Dnte of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Mnnn of injury ..... Injured at work?

23. SIGNATURE: Harold Nergen MD (M. D. or other)
Address: Maryland Nat'l Date signed 12/12/47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

11416

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Near Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

6415 River Road.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Near Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6415 River Rd. R.F.D. # 3

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME

CLAUDE McLAUGHLIN

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ********

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 19, 1884

8. AGE: Years	Months	Days	If less than one day
63	6	12	..... hrs. ..... min.

9. Birthplace: Georgia (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Resturant

FATHER — 12. Name: Frank McLaughlin

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: Sue Mathis

MOTHER — 15. Birthplace: Georgia

16. Informant: Miss Gertrude Smith

Address: 6415 River Rd. Bethesda, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 12-3-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemet ery

Location: Suitland, Md.

18. Funeral director: Wm. Reubens Sumphrey

Address: 7557 Wis. Ave. Bethesda, Md

19. 12/2 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 1 1947, at 7:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947 to Dec 1 1947

and that I last saw her alive on Dec. 1 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	3 days +
Due to: Arterial Hypertension	10 yrs +
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. Marie Page M.D. M.D. or other

Address: 1150 Conn. Ave. Washington D.C. Date signed: 11-2-47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11417

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Montgomery
City or town: Rural-Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred: Waverly Sanitarium
How long in hospital or institution? 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Rural-Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rockville Pike
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Minna Leigh Mercer, Minna Leigh

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Carroll Mercer
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): June 18, 1863

8. AGE: Years: 84 | Months: | Days: | If less than one day: ... hrs. ... min.

9. Birthplace: Norfolk, Va. (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business: —

FATHER
12. Name: John Tunis
13. Birthplace: Va.

MOTHER
14. Maiden name: Caroline Henderson
15. Birthplace: N. C.

16. Informant: Mrs. W. Rutherford
Address: Allamuchy, N. J.

17. (Burial) cremation, or removal. Which?: Burial — Date thereof: Dec. 28, 1947 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: Jas. Sanderson
Address: 1776 Pa. Ave. N. W.

19. 12-26-1947 (Date rec'd by registrar) — M E Jobes — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1947, at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 15, 1946, to Dec. 25, 1947
and that I last saw her alive on December 25, 1947

Immediate cause of death	DURATION
Chronic myocardial insufficiency.	5 years
Due to Arteriosclerosis.	7 years
Due to	
Other conditions Chronic nephritis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ...
Means of injury: ... Injured at work?

23. SIGNATURE: Wheeler D. Huff M.D.
M.D. or other
Address: Bethesda, Md. Date signed: 12-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B 11413

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 3 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C County:

City or town: Washington,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3516 Lowell St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: MORGAN, Luman Edgar

3.(b) Social Security Number:

4. Sex: male (MALE)

5. Color or race: W-US

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Kathleen Morgan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 20, 1883

8. AGE: Years 64 (64) | Months 8 | Days 15 | If less than one day: hrs. min.

9. Birthplace: Ill. (Town, county, and state)

10. Usual occupation: Retired Navy

11. Industry or business:

FATHER

12. Name: MORGAN, Lunan dec

13. Birthplace: N.Y.

MOTHER

14. Maiden name: HADDEN, Alma dec

15. Birthplace: Ill.

16. Informant: Mrs. Kathleen Morgan

Address: 3516 Lowell St., N.W., Wash., D.C.

17. cremation (Burial, cremation, or removal. Which?) Date thereof: 12-8-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. HINES

Address: 2901 14th St., N.W., Wash., D.C.

19. 12-5-47 (Date rec'd by registrar) cc Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 19 47 at 12:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 19 47 to 5 December 19 47 and that I last saw him alive on 5 December 19 47

	DURATION
Immediate cause of death: Coronary Heart Disease, Arterio-	1945
sclerotic	
Due to: Arteriosclerosis General	1945
Due to: Diabetis Mellitus	1917
Other conditions: Arteriolonephrosclerosis	1945
Pulmonary Congestion, left lower lobe	1 day

(over) (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T. E. JARRETT, Cdr. MC USN

M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

		Duration
Other conditions (con't)	Gangrene of left 2nd and fourth toes	- 10-29-47
	Amputation suprocandyle, rt. leg	1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

60+ 11419

Reg. Dist. No. 2 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Derwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
None
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Derwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME ********** ALLETTA MAGRUDER MUNCASTER **********

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John E. Muncaster
6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) January 23, 1874

8. AGE: Years	Months	Days	If less than one day
73 73	10	20	— hrs. — min.

9. Birthplace Montgomery County, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business None
FATHER 12. Name Thomas W. Waters
13. Birthplace Montgomery County, Maryland
MOTHER 14. Maiden name Mary E. Magruder
15. Birthplace Montgomery County, Maryland
16. Informant Miss Emma Muncaster (daughter)
Address Derwood, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 16, 1947 (month) (day) (year)
Cemetery or crematory Rockville Union Cemetery
Location Rockville, Maryland
18. Funeral director Wm. Rawlson Pumphrey
Address Rockville, Maryland
19. 2-16 1947 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1947 at 11 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19.. to Dec. 13 1947
and that I last saw h.. alive on December 13 1947

Immediate cause of death	DURATION
Carcinoma of left breast, with metastasis to lungs	4 years
Due to	
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations None (Irradiation) Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. A. Linthicum, M.D. M. D. or other
Address Rockville Md. Date signed 12/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c 11420

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery Co.
City or town: 4406 Lelan St., Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
4406 Lelan St., Chevy Chase Md.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montg.
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4406 Lelan St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Frederick Malcolm Offutt

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 16, 1923

8. AGE:

Years	Months	Days	If less than one day
24	7	21	____ hrs. ____ min.

9. Birthplace: Bethesda, Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: Frederick J. Offutt
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lula B. Heffner
15. Birthplace: Maryland

18. Informant: Frederick J. Offutt
Address: 4406 Lelan St., Chevy Chase Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/9/47 (month) (day) (year)
Cemetery or crematory: Oak Hill
Location: D. C.

18. Funeral director: W. Reuben Thompson
Address: Bethesda, Maryland

19. 12/8 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 7 1947, at 6:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 1947 to Dec 7 1947 and that I last saw h____ alive on Dec 7 1947

Immediate cause of death	DURATION
Gun shot wound Chest	died instantly
Due to Heart (Suicide)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: 12-7-47
Where did injury occur? Chevy Chase (City or town) Montg. (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: 22 Cal rifle shot Injured at work?

23. SIGNATURE: Frank J. Brocchart M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed: 12-7-47

VS-A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11421

46b+

B

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~49~~ 1 month, 8 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County

City or town Maurertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war WWI & WWII

3.(a) FULL NAME: OVERACKER, Bailey Brooks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 1, 1897

8. AGE: Years	Months	Days	If less than one day
49	11	19	hrs. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER

12. Name OVERACKER, Charles M.

13. Birthplace Fla.

MOTHER

14. Maiden name ELSTON, Daisy D.

15. Birthplace N.Y.

16. Informant mother: Mrs. Daisy D. Overacker

Address Maurertown, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-13-47 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Washington, D.C.

18. Funeral director Arthur J. Walters

Address 254 Carroll Ave., Takoma Park, Md.

19. 12-12 1947 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 December 1947, at 3:28 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1947, to Dec. 12 1947 and that I last saw h im alive on 12 Dec. 1947

Immediate cause of death	DURATION
Adenocarcinoma of stomach	Indefinite Months
Due to	
Due to	
Other conditions Peritonitis general acute	Indefinite days
Pneumonia Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings of operation adenocarcinoma of stomach with perforation & peritonitis Date of op. Nov 18 1947

Autopsy results Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. N. SHELLEY, Cdr. MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 12-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11422

Reg. Dist. No. 212

1. PLACE OF DEATH:
County Montgomery
City or town Barnesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Life
How long in hospital or institution? non

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infanta give residence of mother)
State Md. County Monty.
City or town Barnesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Henry Owens

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 25 1876

8. AGE: Years	Months	Days	If less than one day
71			..... hrs. ..... min.

9. Birthplace Barnesville Monty Co Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name James H. Owens
13. Birthplace Barnesville Md
MOTHER 14. Maiden name Evelyn L. Martin
15. Birthplace Monty Co
16. Informant Laura Owens
Address Barnesville. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/13/47 (month) (day) (year)
Cemetery or crematory Mt Zion
Location near Barnesville Md
18. Funeral director Clarence H Davis
Address Poolesville Md
19. Dec 13 1947 (Date rec'd by registrar) Mrs. C.C. Hilton By Mrs. C.C.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1947, at 945 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 14 1947, to Dec 11 1947
and that I last saw h. alive on Nov 20, 1947

Immediate cause of death	DURATION
Congestive heart failure	1 day
Due to Generalized arteriosclerosis.	
Due to	
Other conditions Left hemiplegia	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. H. Adams M.D. M. D. or other
Address Poolesville Md Date signed 12/12/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11423

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years.

Hospital, institution, or street address where death occurred:

4918 Montgomery Lane.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County Montgomery.

City or town Bethesda.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4918 Montgomery Lane.

(If rural, give LOCATION)

2.(a) If veteran, name war None.

3.(a) FULL NAME Philip Brotherton Parke.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Married.

6.(b) Name of husband or wife Mary Lee Parke.

6.(c) If alive, give age 72. years

7. Birth date of deceased (mo., day, yr.) Dec. 15. 1868.

8. AGE: Years	Months	Days	If less than one day
77	0	15	..... hrs. ..... min.

9. Birthplace Bloomington. Illinois.
(Town, county, and state)

10. Usual occupation Manager of Penn Brew of Southern Richmond

11. Industry or business Southern Richmond.

FATHER
12. Name Cassell Buckley Parke.
13. Birthplace Springfield Mass.

MOTHER
14. Maiden name Adda M. Stiglemeier.
15. Birthplace Alton Ill.

16. Informant Wife.
Address 4918 Montgomery Lane. Beth.

17. Cremation Date thereof Jan 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Edgar Hill Crematory

Location Cedar Hill Cemetery Washington D.C.

18. Funeral director Joseph Gawler's Sons

Address 1756 Penna. Ave, N.W.

19. 12/31 1947 M E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Dec. 1947, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 23 Jan. 1947, to Dec. 30 1947 and that I last saw h. l. m. alive on 30 Dec. 1947

Immediate cause of death	OURATION
Arterial Hypertension Cerebral Hemorrhage Cerebral Hemorrhage	3 hr. 1945-1946.
Due to Arteri sclerosis - generalized	20 yr.
Due to Arterial Hypertension	5 yr.
Other conditions Papilloma of urinary bladder	4 yr.

(Include pregnancy within 3 months of death)

Major findings at operations Papilloma of Bladder - partly removed Date of op. Sept 18 1944

Autopsy results None performed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John H. Bell M.D.
M. D. or other

Address 7956 Eastern Rd Bethesda Md. Date signed 31 Dec 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55 et

11424

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 ~~months 15 days~~ ? 7 yrs

Hospital, institution, or street address where death occurred:

Washington San. & Hosp.

How long in hospital or institution? 2 months 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 Jackson Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Payne, Mrs Lillie App A

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	~~widowed~~ divorced

6.(b) Name of husband or wife Payne, Arthur Ernest

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1884

8. AGE: Years	Months	Days	If less than one day
63	2	20	..... hrs. ..... min.

9. Birthplace Blossburg, Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Bailey, James

13. Birthplace Pa.

MOTHER 14. Maiden name Ingels, Emmagene

15. Birthplace Pa.

16. Informant Hospital Admission Record from Catherine Chaney-Daughter

Address 509 Jackson Ave Takoma Park, Maryland

17. ~~Removal~~ Burial Date thereof 12/13/47 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Prince Georges County, Md.

18. Funeral director S. H. Hines Co.

Address 2901-14 St. N.E. Wash. D.C.

19. 12/11 19 47 J. Hamm D.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1947 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 7, 1947 to Dec. 11, 1947

and that I last saw her alive on Dec. 11, 1947

Immediate cause of death: Generalized adenocarcinomatosis — DURATION: about 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: same as above — Date of op. 8-7-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Paul V. Starr, M.D. (M. D. or other)

Address Takoma Park, Md. Date signed 12-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11425

46 f

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 12-9-47

Hospital, Institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd. - Bethesda Md.

How long in hospital or Institution? Since 12-9-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Mont.

City or town Kirk's Farm

(If outside city or town limits, write RURAL and give nearest town)

Street No. Forest Glen Rd.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Perry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	?

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889 (?)

8. AGE: Years	Months	Days	If less than one day
58 (?)			hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER 12. Name (?)

13. Birthplace (?)

MOTHER 14. Maiden name (?)

15. Birthplace (?)

16. Informant T. W. Kirk

Address Forest Glen Rd. - Kensington Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31, 1947 (month) (day) (year)

Cemetery or crematory County Home

Location Rockville, Md.

18. Funeral director R. F. Snyder

Address Rockville, Md.

19. 12/31 1947 (Date rec'd by registrar) Wm E Gobeo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1947 at 12:11 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-9 1947, to 12-28 1947

and that I last saw h alive on 1947

Immediate cause of death	DURATION
Carcinoma	
Primary site: liver (12/26/48 dictated)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Ephraim Lynenes M.D. M. D. or other

Address Date signed

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11426

Reg. Dist. No. 218

1. PLACE OF DEATH: County: Montgomery
City or town: Etchison MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland, MD. County: Montgomery
City or town: Etchison, MD. Rural R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Laura M. Price

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 17, 1863

8. AGE: Years	Months	Days	If less than one day
84	3	9	..... hrs. ..... min.

9. Birthplace: Maryland, (Town, county, and state)

10. Usual occupation: none

11. Industry or business: None

FATHER
12. Name: Franklin M. Price
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Laura Bready Price
15. Birthplace: Maryland

16. Informant: Caroline W. Price
Address: Gaithersburg, MD. R.F.D.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec. 28. 1947 (month) (day) (year)
Cemetery or crematory: MT Tabor MD.
Location: Etchison, MD.

18. Funeral director: Roy W. Barber
Address: Laytonsville, MD.

19. 12/27/47 (Date rec'd by registrar) L. O. Gall Registrar Dept.

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~[illegible]~~ Dec. 26 1947 at 9 10 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 14 1947 to Dec. 25 1947 and that I last saw h... alive on Dec. 25 1947

Immediate cause of death	DURATION
Uremia,	two weeks
uremia	
Due to: Hypertensive Heart Disease	Unknown
Due to:	
Other conditions: Generalized arteriosclerosis, Senility	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Jack Lemmaster M.D. M. D. or other
Address: Laytonsville Md. Date signed 26 Dec 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

11427

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9320 Old Georgetown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alexander Quinn

3.(b) Social Security Number:

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Sallie
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): May 2, 1869.
8. AGE: Years: 78 | Months: 7 | Days: 0 | If less than one day: ____ hrs. ____ min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Paper seller
11. Industry or business
12. FATHER — Name: Robert Quinn
13. FATHER — Birthplace: ?
14. MOTHER — Maiden name: ?
15. MOTHER — Birthplace: ?
16. Informant: Hospital Records
Address: Suburban Hospital
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/5/47 (month) (day) (year)
Cemetery or crematory
Location: Roanoke Virginia
18. Funeral director: W. W Chandler Co
Address: 1400 Chapin St N.W.
19. Dec 3rd 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2, 1947 at 5 10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1947 to Dec 2 1947 and that I last saw h...im alive on Dec. 2 1947

	DURATION
Immediate cause of death: Heart failure	
Due to: cardiovascular renal	
hepato-renal syndrome	?
Due to: Cirrhosis cirrhosis	
Other conditions: Emaciation	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: John G. Fawcett M.D.
M. D. or other
Address: Suburban Hosp. Bethesda Date signed 3 Dec 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

11428

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred:
2 Williams Ln
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: M.D. County: MONTGOMERY.
City or town: CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 WILLIAMS LANE
(If rural, give LOCATION)
2.(a) If veteran, name war: NO

3.(a) FULL NAME: MARY C. RAFTERY.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	widowed

6.(b) Name of husband or wife: PATRICK RAFTERY.
6.(c) If alive, give age: ... years
7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
77	?	?	— hrs. — min.

9. Birthplace: BALTIMORE Md.
(Town, county, and state)
10. Usual occupation: HOUSEWORK.
11. Industry or business:
FATHER 12. Name: THOMAS WELCH.
13. Birthplace: IRELAND.
MOTHER 14. Maiden name: CATHERINE CARLUS
15. Birthplace: IRELAND.
16. Informant: Mrs. John O'Neill
Address: 2 William Lane.
17. Burial, cremation, or removal. Which?: Burial Date thereof: DEC 17th 47 (mooth) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Washington D.C.
18. Funeral director: J.F. Costello
Address: 1722 North Cap St. Wash. D.C.
19. (Date rec'd by registrar): 12/15 1947
Registrar: W E Johns

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1947 at 2:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1939 to December 14 1947 and that I last saw h[illegible] alive on December 14 1947

Immediate cause of death	DURATION
Arteriosclerosis	10 Years or more
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ...
Means of injury: ... Injured at work?

23. SIGNATURE: Michael J. McInerney M.D.
M. D. or other
Address: 1150 Conn Avenue Washington, D.C. Date signed: 12-14-47

VS A15

MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11429

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46e JB

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Lorton (rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

REID, Silas (nmi)

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	white	?

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 24 October 1874

8. AGE: Years	Months	Days	If less than one day
73	2	2	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER 12. Name: unknown

13. Birthplace

MOTHER 14. Maiden name: unknown

15. Birthplace

16. Informant: Brother: Mr. James W. Reid

Address: Lorton, Virginia

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Beullah Cemetery

Location: Occoquan, Virginia

18. Funeral director: Hall Funeral Home F.L.B.

Address: Occoquan, Virginia

19. 12-27 19 47 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 December 19 47 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-11- 19 47 to 12-26- 19 47 and that I last saw h im alive on 12-26- 19 47

Immediate cause of death	DURATION
Carcinoma, lower bowel	
& metastasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. E. Marland, Jr.
A. E. MARLAND, Jr. Lt. JG MC USN

Address: USNH Bethesda, Md. M. D. or other: Date signed: 12-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Evidence for the change of year of birth and age shown on G 114 12/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52 f

S 11430

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4411 Albemarle St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: REYNOLDS, Louis Charles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Kenitha K. Reynolds

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 29, ~~1889~~ 1898

8. AGE: Years	Months	Days	If less than one day
49 ~~59~~ / ~~58~~	4	18	hrs. min.

8. Birthplace: N.Y.
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: REYNOLDS, Frank M. dec
13. Birthplace: N.Y.

MOTHER
14. Maiden name: MILLER, Louise dec
15. Birthplace: N.Y.

16. Informant: wife: Mrs. Kenitha K. Reynolds
Address: 4411 Albemarle St., N.W., Wash., D.C.

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: 12-19-47
(month) (day) (year)

Cemetery or crematory: ~~Prospect~~ Hill Cemetery

Location: Washington, D.C.

18. Funeral director: S. H. HINES, ~~Wm.~~

Address: 2901 14th St., N.W., Wash., D.C.

19. 12-17 19 47 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 17 19 47 at 3:16A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Dec. 19 47 to 17 Dec. 19 47 and that I last saw him alive on 17 Dec. 19 47

Immediate cause of death	DURATION
Hyperseplasma metastasis	2
To lungs	
Due to	
Due to	
Other conditions: Bronchopneumonia	2 weeks
Colitis, Carcinoma	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Confirmed Cancer

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: P. L. BATES, Lt. JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11431

1602

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. R# 2 - Seven Locks Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alfred Harry Ricketts

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1947

8. AGE:

Years	Months	Days	If less than one day
0	0	0	1 hrs. 35 min.

9. Birthplace Olney, Montgomery Co. Maryland (Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER

12. Name Russell Lee Ricketts

13. Birthplace Rockville, Md.

MOTHER

14. Maiden name Jean Randolph Sangster

15. Birthplace Washington, D.C.

16. Informant Hospital Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec 6 1947 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Wm Reuben Pumphrey

Address Bethesda Md

19. Dec 6 1947 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1947 at 4:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1947 to Dec 6 1947 and that I last saw h. alive on Dec 6 1947

Immediate cause of death	DURATION
Congenital Atelectasis	
Due to Prematurity	
Due to (Underlying) Marginal Placenta Previa	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Figurelli M. D. or other

Address Sandy Spring Md Date signed Dec 6 '47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11432

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Gaithersburg (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ? Found dead along highway

Hospital, institution, or street address where death occurred:
Co. Old Baltimore Rd & Yaskin Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1840 Metwood Pl. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Laurence A. Robbins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE:

Years	Months	Days	If less than one day
77			..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Retired (Druggist)

11. Industry or business: —

FATHER
12. Name: unknown
13. Birthplace: —

MOTHER
14. Maiden name: unknown
15. Birthplace: —

16. Informant: William B Robbins
Address: 1840 Metwood Pl. N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 26 47 (month) (day) (year)

Cemetery or crematory: Penn Yan Cemetery

Location: Penn Yan N.Y.

18. Funeral director: Ernest C Gaither

Address: Gaithersburg md

19. Dec 23 19 47 (Date rec'd by registrar) Abner L Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 22 19 47 at 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec med exam 19 ..... to ..... 19 .....
and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary occlusion	died
Due to	.....
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brochant Dep. med. exam. M. D. or other

Address: Gaithersburg md Date signed 12-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11433

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred: Washington Sanitarium + Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: MONTGOMERY

City or town: TAKOMA PARK.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 23 Woodland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CHESTER LEROY ROGERS.

3.(b) Social Security Number: NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED.

6.(b) Name of husband or wife: ANNA J. ROGERS

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): NOV. 18, 1894

8. AGE:

Years	Months	Days	If less than one day
53	1	6	....hrs. ....min.

9. Birthplace: NEWBERG OREGON. (Town, county, and state)

10. Usual occupation: SECRETARY

11. Industry or business: GENERAL CONF. of S.D.A's.

FATHER

12. Name: FRED REED ROGERS.

13. Birthplace: MINN.

MOTHER

14. Maiden name: MINNIE GROVES

15. Birthplace: NEW YORK.

16. Informant: ANNA J. ROGERS

Address: 23 WOODLAND AVE

17. Burial (Burial, cremation, or removal. Which?) Date thereof: DEC. 27 1947 (month) (day) (year)

Cemetery or crematory: Mt. Lincoln Cemetery

Location: Bladensburg Road at Dist. Line

18. Funeral director: Arthur Sothoron

Address: 254 Carroll Ave. Takoma Park D.C.

19. 12/25/47 19.... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 24th 1947 at 955 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Past three years or more to ....19.... and that I last saw h... alive on Dec 24 1947

Immediate cause of death	DURATION
(1) Cerebral thrombosis	recurrent
Due to: following cerebral hemorrhage	2 yrs.
(2) Partial to complete intestinal obstruction	2 days
Due to: Probable Cerebral thrombosis (terminal)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: as above

Date of op. ....

Autopsy results: Pm

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: 0 Date of ....

Where did injury occur? 0 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: 0 Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 500 Underwood Date signed: 12/26/47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46-X (B) 11434

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mon, 14 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 mon, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1600 17th St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: RUGGLES, Benjamin Hollis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 23, 1896

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
51	2	18		

9. Birthplace: Washington State
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Navy Yard, Wash., D.C.

FATHER 12. Name: RUGGLES, William Nelson dec

13. Birthplace: Ark.

MOTHER 14. Maiden name: HOLLIS, Harriet

15. Birthplace: Ind.

16. Informant: mother: Mrs. Harriet Wait

Address: 1600 17th St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-15-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 517 11th St., S.E., Wash., D.C.

19. 12-12 19 47 (Date rec'd by registrar)

Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11 19 47 at 8:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Oct. 1947, to 11 Dec. 1947 and that I last saw him alive on December 11 1947

Immediate cause of death	DURATION
Bronchopneumonia	24 hrs.
Due to: Carcinoma, Stomach	2 yrs
Due to:	
Other conditions: Gastrojejunostomy, surgical (Include pregnancy within 3 months of death)	14 months

Major findings of operation:

Date of op.:

Autopsy results: Adenocarcinomas stomach

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. A. Dinsmore Jr.
W. A. DINSMORE, Jr., LCDR MC USN

Address: USNH Bethesda, Md. M. D. or other

Date signed: 12-12-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11435

131a

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred: Georgia Rest Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 140 Baltimore Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth I. Sage

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 14-1870

8. AGE:

Years	Months	Days	If less than one day
77	10	2	....hrs. ....min.

9. Birthplace: Washington D. C.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Chas. C. Troy
13. Birthplace: Wash. D. C.

MOTHER
14. Maiden name: M. Georgeanna Curran
15. Birthplace: Wash. D. C.

16. Informant: Clyde L. Garrett, Lawyer
Address: Colorado Bldg. Washington, D. C.

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: Dec 19 1947
(month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: D. C.

18. Funeral director: Lee Funeral Home

Address: 300 - 4th St. N.E. Wash. D.C.

19. Dec. 17 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16, 1947, at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947, to Dec. 16 1947

and that I last saw her alive on Dec. 16 1947

Immediate cause of death	DURATION
Cardio-Vascular-Renal Disease	Several yrs.
Due to: Senility.	several yrs.
Due to:	
Other conditions: Parkinson's Syndrome	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lynwood Sledge M.D.
M. D. or other

Address: 6940 Piney Branch Rd. Wash. D.C.

Date signed: 12/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a 11436

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery County

City or town: Takoma Park.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 22 days 19 hrs 35 min

Hospital, institution, or street address where death occurred:

Washington San. & Hosp. Takoma Park

How long in hospital or institution? 1 month 22 days 19 hrs 15 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md. County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 911 Davis Ave.

(If rural, give LOCATION)

3.(a) If veteran, name war

3. (a) FULL NAME: Shellenberger (Mrs Margaret.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	

6.(b) Name of husband or wife: Shellenberger

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 27, 1874.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
73	9	29		

9. Birthplace: Charles Co. md.

(Town, county, and state)

10. Usual occupation: House wife.

11. Industry or business:

FATHER — 12. Name: Joseph Henry Fowler

13. Birthplace: Charles Co Md.

MOTHER — 14. Maiden name: Sarah Ellen Shorter

15. Birthplace: Charles Co. md.

16. Informant: Washington San & Hosp. Record

Address: Takoma Park md.

17. ~~Removal Burial~~ (Burial, cremation, or removal. Which?) Date thereof 12/30/47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Washington D.C. Arlington Va.

18. Funeral director: S. H. Stines Co.

Address: 2901 - 14th St. N.W.

19. Dec. 26 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 19 47 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23 19 47 to Dec. 25 19 47 and that I last saw h.. alive on December 25, 19 47

Immediate cause of death	DURATION
Malnutrition	
with Acidosis and Multiple	
Sloughing Decubitus Ulcers	7 weeks
Due to Fracture of Surgical neck	
of right Humerus	3 mo. 2 days
Due to Parkinson's Disease	6 yrs ?
Other conditions Hypertrophic Arthritis	6 yrs ?
with marked Kyphosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9-23-47

Where did injury occur? Takoma Pk., Prince Geo. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Nursing home

Means of injury: Tripped and fell Injured at work? No

23. SIGNATURE: Wallace L. Nook M.D.

(M. D. or other)

Address: 805 Carroll Ave. Takoma Park, Md. Date signed: 12-26-47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46e + 11437

Reg. Diat. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: The Montgomery County General Hospital Dec.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Germantown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Ethel Spates

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1884

8. AGE: Years	Months	Days	If less than one day
63	3	14	hrs. min.

9. Birthplace Germantown, Maryland (Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Horace D. Waters

FATHER 13. Birthplace Germantown, Maryland

MOTHER 14. Maiden name Valeria Pumphrey

MOTHER 15. Birthplace Germantown, Maryland.

16. Informant Hospital records.

Address Olney, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-8-47 (month) (day) (year)

Cemetery or crematory Meadowville

Location Meadowville, Md.

18. Funeral director Wm Reuben Umphrey

Address Bethesda, Md

19. Dec 6 1947 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1947 at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1947 to December 6 1947 and that I last saw her alive on December 6 1947

Immediate cause of death	DURATION
Secondary anemia	3 mo
Due to Carcinoma of large intestinal tract	8 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. J. Brochard M.D. M. D. or other

Address Gaithersburg, Maryland Date signed 12/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11438

Reg. Dist. No. 916

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs.
Hospital, institution, or street address where death occurred:
6301 Broad Branch Road
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6301 Broad Branch Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: LELIA A. STONE

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John P. Stone
6.(c) If alive, give age: dec'd years

7. Birth date of deceased (mo., day, yr.): April 19, 1866

8. AGE: Years	Months	Days	If less than one day
81 81	7	27	hrs. min.

9. Birthplace: Montgomery County, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: William M. Hardesty
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha E. Renshaw
15. Birthplace: Maryland

16. Informant: Mrs. Effie E. Shaw (daughter)
Address: Chevy Chase, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/18/47 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: Wm. Reuben Ramsburg
Address: Bethesda, Maryland

19. 12/18/47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16th, 1947, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 — 1947 to Dec. 15 — 1947 and that I last saw her alive on December 15 — 1947.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Arterio-sclerosis	8 years
Due to: Senility	—
Other conditions: Chronic nephritis	8 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wheeler D. Huff, M. D. or other
Address: Bethesda, Md. Date signed: 12-17-47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11439

932

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 23 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N.J. County:

City or town: Mahwah
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Alcot Road
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: STONE, Ralph William

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 19, 1891

8. AGE:

Years	Months	Days	If less than one day
56	1	10	hrs. min.

9. Birthplace: Mass.
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: STONE, Albert dec.
13. Birthplace: Mass.

MOTHER
14. Maiden name: KNIGHT, Georgia Anna dec.
15. Birthplace: Mass.

16. Informant: SISTER: Mrs. Alice Kennedy
Address: Alcot Road, Mahwah, N.J.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-31-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: S. H. HINES
Address: 2901 14th St., N.W., Wash., D.C.

19. 12-30 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 December 19 47 at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 November 19 47 to 29 Dec 19 47 and that I last saw him alive on 29 Dec. 19 47

Immediate cause of death	DURATION
Coronary obstruction	hrs.
Due to: Coronary Thrombosis	36 hrs
Due to: Coronary Sclerosis and Hypertensive Vascular Disease	yrs.
Other conditions: 2 Pneumonia Coronary Thrombosis	6 mo

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D E Billman Jr M
D. E. BILLMAN, Lt.JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-30-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160a

S 11440

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 hours

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7317 Alaska Avenue, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SULLIVAN, Gerard Dennis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 28 December 1947

8. AGE: Years	Months	Days	If less than one day
			8 hrs. min.

9. Birthplace: Bethesda, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: SULLIVAN, Arthur Dennis
13. Birthplace: N.J.

MOTHER
14. Maiden name: CONGER, Delores
15. Birthplace: Canal Zone

16. Informant: FA:Lt.Cdr. Arthur D. Sullivan, USN
Address: USS DAMATO, DD171

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-30-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS & S.
Address: 1400 Chapin St., N. W., Wash., D.C.

19. 12-29 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 December 19 47 at 11:59 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Dec. 19 47 to 28 Dec. 19 47 and that I last saw him alive on 28 Dec. 19 47

Immediate cause of death	DURATION
Premature	
6½ month gestation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Petechial hemorrhages in cerebral and Archnoid and epicardium.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul Peterson
PAUL PETERSON, Capt. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11441

Reg. Diat. No. 514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

106 E Franklin St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Mont.

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 200 E. Hamilton Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Penrose R. Talley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25 1861

8. AGE:

Years	Months	Days	If less than one day
86	4	20	..... hrs. ..... min.

9. Birthplace: Wilmington Del

(Town, county, and state)

10. Usual occupation: retired bookkeeper

11. Industry or business

FATHER

12. Name: Charles Talley

13. Birthplace: Del.

MOTHER

14. Maiden name: Mary Tebley

15. Birthplace: Del.

16. Informant: J. W. Talley

Address: 200 E. Hamilton St. Silver Spring Md.

17. Burial + Cremation (Burial, cremation, or removal. Which?) Date thereof: Dec 17, 1947 (month) (day) (year)

Cemetery or crematory: Chester Bethel

Location: Wilmington Delaware

18. Funeral director: The S.H. Hines Co

Address: 2901 14th St N.W. Wash. D.C.

19. Dec 15 1947 (Date rec'd by registrar) Josephine M. Cahoon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 1947, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam Case 19.., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bronstrat M.D. Med. Exam., M. D. or other

Address: Wilmington Del. Date signed: 12-15-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11442

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs., 50 minutes

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 hrs., 50 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: P.G.

City or town: Suitland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4348 Spring Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: TAYLOR, Baby Girl

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 10, 1947

8. AGE: Years | Months | Days | If less than one day: 4 hrs. 50 min.

9. Birthplace: Bethesda, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER

12. Name: TAYLOR, Clarence Paul

13. Birthplace:

MOTHER

14. Maiden name: JAREWSKI, Helen Sophie

15. Birthplace: Penn.

16. Informant: father: Mr. Clarence P. Taylor

Address: 4348 Spring St., Suitland, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-16-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS $29.

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 12-15 (Date rec'd by registrar) 19 47 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 Dec. 1947 at 3:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Dec. 1947 to 11 Dec. 1947 and that I last saw her alive on 11 Dec. 1947

Immediate cause of death	DURATION
Premature - 6 mo. gestation -	
Due to	
Due to	
Other conditions: No abnormalities except prematurity	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: PAUL PETERSON, Capt. MC USN

M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-15-47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

74a+

11443

Reg. Dist. No. 714

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: 1539-Red Oak Dr.
City or town: Silver-Spring-Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Montgomery
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1539-Red Oak Dr. Sil. Spg. Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sidney Andrew Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen E. Taylor
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept-26-1904

8. AGE: Years	Months	Days	If less than one day
43			hrs. min.

9. Birthplace: Chase City-Va.
(Town, county, and state)
10. Usual occupation: Service Station Lessee
11. Industry or business:

FATHER
12. Name: Benjamin Taylor
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Helen E. Taylor
Address: 1539-Red Oak Dr. Sil. Spg. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec 10, 1947 (month) (day) (year)
Cemetery or crematory: Oxford N. C.
Location: Dec-10-47
18. Funeral director: Neal Funeral Home
Address: 4812-Georgia Av- Wash-D.C.

19. Dec 8 1947 (Date rec'd by registrar) Josephine M Schuyler (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 8 1947, at 9.30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 1 1947, to Dec 8 1947; and that I last saw him alive on Dec. 7 1947.

	DURATION
Immediate cause of death: Leukemia	6 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Bullock M. D.
M. D. or other
Address: 766 Rock Cr. Ch. Rd. Date signed: Dec 8

Ge 5701

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

B 11444 216

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day, 3 hours

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 day, 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County .....

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7008 McArthur Blvd.,
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME TAYLOR, Walton (n)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife Mary Taylor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 4, 1891

8. AGE: Years	Months	Days	If less than one day
56	11	10	..... hrs. ..... min.

9. Birthplace Va. (Town, county, and state)

10. Usual occupation Policeman

11. Industry or business Capitol Police

FATHER 12. Name TAYLOR, Robert dec.

13. Birthplace unknown

MOTHER 14. Maiden name TUCKER, Sophie dec.

15. Birthplace unknown

16. Informant wife: Mrs. Mary Taylor

Address 7008 McArthur Blvd., N.W., Wash., D.C.

17. burial Date thereof 12-23-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. CHAMBERS M.R.

Address Georgetown, D.C.

19. 12-22 19 47 Mary C. Patterson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 19 47 at 7:18 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 Dec. 19 47 to 20 Dec. 19 47 and that I last saw him alive on 20 Dec. 19 47

	DURATION
Immediate cause of death	
Hemorrhage, cerebral	4 Days
Due to Hypertension	indef
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results intraventricular Hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. L. Fleck R. L. FLECK, Lt. MC USN
M. D. or other

Address USNH Bethesda, Md. Date signed 12-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1315a

1145

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery -

City or town Olney -

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Montgomery Co. Gen. Hospital

How long in hospital or institution? Thirteen

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg (If outside city or town limits, write RURAL and give nearest town) Rfd 6 Rural

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Katie Thomas -

3. (b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married -

6.(b) Name of husband or wife William Thomas -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 14th 1886 -

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
61	3 -	5		52

9. Birthplace Oct 14th 1886 Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name James V. Wallace

13. Birthplace Mont. Co. Md -

MOTHER 14. Maiden name Lucinda King

15. Birthplace Maryland -

16. Informant Hospital

Address Olney - Md -

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22 1947 (month) (day) (year)

Cemetery or crematory Howard Chapel

Location Montgomery Co Md

18. Funeral director Roy W Barber

Address Laytonsville Md

19. Dec 22 1947 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1947 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7, 1947, to December 19, 1947 and that I last saw her alive on December 19, 1947

Immediate cause of death	DURATION
Uremia	12 days
Due to Arteriolo Nephrosclerosis 1315a	8 years
Due to Hypertensive Cardiovascular Disease	? years
Other conditions Bronchopneumonia (recovered)	1 wk

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert R. Williams M. D. or other

Address Mont. County Gen. Hospital Date signed 12-19-47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a (S) 11446

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6½ days

Hospital, institution, or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? 6½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1608 Michigan Ave. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Turner, Mrs Jane Eliza

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 29, 1857

8. AGE: Years: 90 | Months: 2 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Howell, McLewis

13. Birthplace: Warrenton, Virginia

MOTHER

14. Maiden name: Mount joy, Hester

15. Birthplace: Warrenton, Virginia

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Maryland

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof: Dec. 21 1947 (month) (day) (year)

Cemetery or crematory: Congressional Cemetery

Location: Washington D.C.

18. Funeral director: Lee Funeral Home

Address: 4th & Mass. Ave. N.E. D.C.

19. Dec. 18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 18 1947 at 6:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 1947, to Dec. 18 1947

and that I last saw h... alive on Dec. 17 1947

	DURATION
Immediate cause of death: Fractured skull (basilar portion)	hrs.
Due to: fall	1 hr
Due to:	
Other conditions: Fractured neck of femur. Cystocele. Senility	1 hr. 6 mos. ? yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~: Date of Dec. 18 1947

Where did injury occur? Washington (City or town) (County) D.C. (State)

Injured at ~~home, farm, industry, public place (where?)~~:

Means of injury: fall Injured at work? no

23. SIGNATURE: Russell A. Dunn, M.D.

M. D. or other

Address: Washington Sanitarium Date signed: Dec. 18, 1947

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11447

46 Pct

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 22 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Calvert

City or town: Huntingtown
(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: TURNER, Thomas Leslie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Mrs. Verda Turner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 15, 1894

8. AGE: Years	Months	Days	If less than one day
53	2	16	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER — 12. Name: Mr. William Turner dec.

13. Birthplace: Md.

MOTHER — 14. Maiden name: Paddy, Jenatta

15. Birthplace: Md.

16. Informant: wife: Mrs. Verda Turner

Address: Huntingtown, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory: All Saints

Location: Sunderland, Md.

18. Funeral director: Wm. H. Hutchins & Sons a.t.b.

Address: Owings, Md.

19. 1-2 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 19 47 at 5:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9 19 47 to 31 Dec. 19 47 and that I last saw him alive on 31 December 19 47

Immediate cause of death	DURATION
Malignant Lymphoma Retroperitoneal in Lungs	8 Months
Due to Metastases to lymph nodes, heart, lung, spleen and pancreas.	
Other conditions atelectasis and Bronchopneumonia	2 MO 7 MO

(Include pregnancy within 3 months of death)

Major findings of operations: Malignant lymphoma Metastatic to right Neck Date of op.

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. T. Jones, Jr. Lt. JgMC USNR M. D. or other

Address: USNHBethesda, Md. Date signed 1-2-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 11448

Reg. Diat. No. 2-16

1. PLACE OF DEATH

County: Montgomery

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred: Bethesda, Maryland

How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Quincy St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME MRS. ANNA H. TUTTLE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Wh.	Widowed

6.(b) Name of husband or wife: LE ROY TUTTLE 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 2, 1864

8. AGE:

Years	Months	Days	If less than one day
83	4	10	hrs. min.

9. Birthplace: Utica, New York (Town, county, and state)

10. Usual occupation: At home

11. Industry or business:

FATHER — 12. Name: HENRY HUNTON HARD

FATHER — 13. Birthplace: NEW YORK

MOTHER — 14. Maiden name: MARGARET A. ROE

MOTHER — 15. Birthplace: NEW YORK

16. Informant: Mrs. Carroll Morgan

Address: 12 Quincy St., Ch. Ch., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 16, 1947 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Wash. D.C.

18. Funeral director: Joseph Gawler's Sons

Address: 1756 Penna. Ave., N.W.

19. 12/12 1947 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 Dec 1947 at 7 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1936, to 12 Dec 1947

and that I last saw her alive on 11 Dec '47 1947

Immediate cause of death	DURATION
Acute Pulmonary Oedema	24 hrs
Due to Arterio-Sclerotic Heart Disease	10 years
Due to	
Other conditions Paralysis Agitans	5 Years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wendell Reed, M.D. M. D. or other

Address: 1150 Connecticut Ave Washington D.C. Date signed: 13 Dec '47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11449

131a

CERTIFICATE OF DEATH

S

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15, 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 3 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or Institution? 1 month, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1229 Gerard St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: WADE, Joseph Ambrose

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 15, 1884

8. AGE: Years	Months	Days	If less than one day
63	3	25	hrs. min.

8. Birthplace: Md. (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER — 12. Name: Wade, Benjamin dec

13. Birthplace: Md.

MOTHER — 14. Maiden name: Duckett, Caroline dec

15. Birthplace: Md.

18. Informant: brother: Mr. James L. Wade

Address: 1229 Gerard St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-13-47 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Wash., D.C.

18. Funeral director: McQuire Funeral Home J.L.M.

Address: 1820 9th St., N.W., Wash., D.C.

19. 12-11 (Date rec'd by registrar) 19 47 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 December 19 47 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Nov. 19 47 to 10 Dec. 19 47 and that I last saw h... in alive on 10 Dec. 19 47

	DURATION
Immediate cause of death: Uremia + acidosis	2 mo
Due to: Hypertensive Cardio Renal Disease.	10 yrs.
Due to:	
Other conditions: Renal Lithiasis ulcerative colitis (Include pregnancy within 3 months of death)	? ?

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

D. E. BILIMAN, Lt. JG MC USN

23. SIGNATURE: M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11450

CERTIFICATE OF DEATH

8

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
8408 Piney Branch Court

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: McKean

City or town: Bradford
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CHARLES M. WAGNER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Emily B.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 7th. 1867

8. AGE: Years	Months	Days	If less than one day
80	9	18	hrs. min.

9. Birthplace: Titisville, N. Y.
(Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business

FATHER 12. Name: Unknown Wagner

13. Birthplace: Germany

MOTHER 14. Maiden name: Caroline Unknown

15. Birthplace: Germany

16. Informant: Mrs. Roland C. Zschiegner

Address: 8408 Piney Branch Court

17. Burial & Trans. Date thereof: 12.25/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Portville, N. Y.

Location:

18. Funeral director: Warner E Pumphrey

Address: Silver Spring, Md.

19. Dec 25 1947 Josephine M. Schaffle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1947 at 1:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep med Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J Borchart M.D.
Dep med Exam
M. D. or other

Address: Gaithersburg md Date signed 12.25.47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11451

830

CERTIFICATE OF DEATH

Reg. Diat. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred: 921 Highland Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 921 Highland Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Magaret Amelia Walker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: George Arthur Walker

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): 9 Nov 1867

8. AGE: Years	Months	Days	If less than one day
80	1	3	hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John A. Giesler

13. Birthplace:

MOTHER — 14. Maiden name: Dorothea Ackler

15. Birthplace: Baltimore, Md

16. Informant: Mrs H E Johnson

Address: 921 Highland Dr, Silver Spring Md

17. (Burial, cremation, or removal. Which?) Date thereof 12-15-47 (month) (day) (year)

Cemetery or crematory: Geo Washington Mem. Park Cem.

Location: Rock Rd. Md

18. Funeral director: William K. Huntemann

Address: 5732 Ga. Ave, N.W., Wash. DC.

19. Dec 12 1947 (Date rec'd by registrar) Josephine M Schaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 Dec 1947, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Nov 1947 to 12 Dec 1947 and that I last saw h.. alive on 11 Dec 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days
Due to: Arteriosclerosis	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William D. Aud, M.D. M. D. or other

Address: Silver Spring Md Date signed 12 Dec 47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

74a +

11452

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 Years
Hospital, institution, or street address where death occurred:
15 James Street,
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 15 James Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: THOMAS MERVIN WARD

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): March 25, 1930

8. AGE: Years	Months	Days	If less than one day
17 17	8	6	hrs. min.

9. Birthplace: Montgomery Co., Maryland (Town, county, and state)
10. Usual occupation: Student
11. Industry or business: High School

FATHER
12. Name: Charles Leslie Ward
13. Birthplace: Montgomery Co., Maryland

MOTHER
14. Maiden name: Daisy Pope Ward
15. Birthplace: Montgomery Co., Maryland

16. Informant: Mrs. Daisy Pope Ward (mother)
Address: Gaithersburg, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3, 1947 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg, Maryland

18. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda, Maryland

19. 12-2-47 (Date rec'd by registrar) 19 Alfred G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1st, 1947 at 2:35A PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1st, 1946 to Nov. 30th, 1947 and that I last saw him alive on November 30th, 1947

	DURATION
Immediate cause of death: Spleno myelogenous leukemia	2 years
Due to: Secondary anemia	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Sandy Spring, Maryland Date signed: 12/1/47

11453

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Christine Elizabeth Baby Girl Waters.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 26, 1947

8. AGE: Years | Months | Days | If less than one day: 7 hrs. 23 min.

9. Birthplace Olney, Md. 26 (Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER — 12. Name James Henry Jones

FATHER — 13. Birthplace

MOTHER — 14. Maiden name Janet Mae Waters

MOTHER — 15. Birthplace Emory Grove, Maryland

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31 1947 (month) (day) (year)

Cemetery or crematory Emory Grove

Location Gaithersburg Md

18. Funeral director Robert L Snowden

Address Rockville Md

19. Dec. 31 1947 (Date rec'd by Registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1947 at 8:31 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26 1947, to December 26 1947 and that I last saw h.e.r. alive on December 26 1947

Immediate cause of death	DURATION
Prematurity	7 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J M B M. D. or other

Address Sandy Spring, Md Date signed 12/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

11455

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town near Damascus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town near Damascus
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. ont. Airy, md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lucie M. N. Whiteside

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband ~~or wife~~ Thomas N. Whiteside
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 5, 1867.

8. AGE: Years 80 | Months 5- | Days 1 | If less than one day ... hrs. ... min.

9. Birthplace Agusta Maine (Town, county, and state)
10. Usual occupation House wife
11. Industry or business Home.
12. FATHER Name James B. Mears
13. Birthplace maine.
14. MOTHER Maiden name Sarah Taylor
15. Birthplace maine.
16. Informant Maynard A. Morris
Address R.F.D. 3 ont. Airy maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9 1947 (month) (day) (year)
Cemetery or crematory Fountain Cemetery
Location Fostoria, Ohio.
18. Funeral director J. B. Beall, Inc.
Address Damascus, md.
19. Dec 7 1947 (Date rec'd by registrar) Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1947 at 8:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept med. Exam 19... to ... 19...
and that I last saw h... alive on Case 19...

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Borchardt M.D. Sept. Med. Exam M. D. or other
Address Gaithersburg md Date signed 12-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1372 — 11456

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 1/2 days

Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? 10 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: District of Col. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1629 Columbia Rd., Arganna Hgts. 406
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Williams, Mr. John Mackey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Blanch Morgan Williams

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 5, 1868

8. AGE: Years	Months	Days	If less than one day
79	4	28	____ hrs. ____ min.

9. Birthplace: Tuckahoe, N. J.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Louis S. Williams

13. Birthplace: Tuckahoe, N. J.

MOTHER — 14. Maiden name: Emma Marshall

15. Birthplace: Tuckahoe, N. J.

16. Informant: Washington Sanitarium & Hospital Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 4 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Congressional

Location: Washington D.C.

18. Funeral director: Harry L. Slye

Address: 1009 H. Street, N.E. Wash. D.C.

19. Dec 2 1947 (Date rec'd by registrar) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 1947, at 9 17 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/30 1936, to Dec 2 1947, and that I last saw h[illegible] alive on Dec 2 1947

Immediate cause of death	DURATION
Pyelonephritis	12 days
Due to: Uremia	3 days
Due to: Gen Arteriosclerosis	
Other conditions: Chronic tuberculosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Howard V. Thomkins M. D. or other

Address: ____ Date signed: 12/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Encircle the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45